IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 38119-I

September 17, 2012

Ms. W. Jean Greeley, Administrator
Prairie Hills at Clinton
1701 13th Avenue
Clinton, IA 52732

RE: Amended Final Recertification and Complaint/Incident Investigation Report, Prairie Hills at Clinton, Clinton, Iowa

Dear Ms. Greeley:

Enclosed is the **Amended Final Recertification and Complaint/Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Recertification and Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiency, DIA accepts the POC. The Request for Reconsideration has been accepted for Food Service and Dementia Specific Education based on information provided by the program.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0243** with effective dates of **September 29, 2012** through **September 28, 2014**.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Amended Final Recertification and Complaint/Incident Investigation Report

Assisted Living Program:

W. Jean Greeley
Prairie Hills Assisted Living at Clinton
1701 13th Ave.
Clinton, Iowa 52732

Complaint/Incident Intake #:

38119-I

Date of Complaint/Incident Investigation:

August 15, 2012

Monitor(s):

Maribeth Freland RN
Joyce Kix RN

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 69 that serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to and approved by the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	58
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	60

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	5
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	11
TOTAL census of Assisted Living Program	71

Program History – The program received regulatory insufficiencies during this certification period in the areas of Service Plan, Medications, Staffing and Evaluations.

Tenant/Family Satisfaction Results – A community meeting was held with six tenants in attendance. The tenants reported general satisfaction with the program. They reported respectful staff interaction and timely response to calls made using emergency pendants. The tenants reported the food served by the program was palatable and the provision of scheduled activities plentiful. They reported the program's environment to be clean and safe, acknowledging they would recommend it to others.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Tenant Rights

Complaint/Incident Allegation: The program reported one tenant had 81 tablets of Vicodin, a narcotic pain killer, missing from a prescription bottle that had been stored in a locked cupboard which could be accessed only by staff members.

- Monitoring Observation: On 2-27-12, program administration became aware of the large amount of Vicodin tablets missing from Tenant #2's prescription bottle, which was stored in Tenant #2's apartment in a locked cupboard that could be accessed only by using a key that is carried by all certified medication assistants (CMA).

  Tenant #2, a 90 year old, was admitted to the program on 5-14-11 with diagnoses of Mild Alzheimer's Dementia, Cardiovascular Disease, Hypertension and Back Pain. Tenant #2 scored a 2 on the Global Deterioration Scale (GDS) completed on 8-9-12, indicating very mild cognitive decline.

Tenant #2 lived in the general population area of the program with his/her spouse and was independent with all personal care tasks but required assistance with medication administration. Documentation indicated Tenant #2 had a physician's order, dated on 1-16-12, for Vicodin 5/500 milligrams (mg) one tablet up to four times daily as needed for pain. The Medication Administration Records (MAR) indicated program staff members administered Vicodin to Tenant #2 eight times in January 2012 and nine times in February 2012 prior to finding the missing medications. The pharmacy delivered 100 Vicodin 5/500 mg tablets to the program on or about 1-16-12. On 2-27-12, Tenant #2 had no Vicodin left in the bottle, leaving 81 tablets unaccounted for.

Staff #1, CMA, administered the Vicodin to Tenant #2 for reported pain on Thursday 2-16-12. Documentation indicated the Vicodin was not administered again until Saturday 2-25-12 by Staff #1. Staff #1 reported noting a mostly full bottle of Vicodin in Tenant #2's locked cupboard on 2-16-12. When Staff #1 opened the Vicodin bottle on 2-25-12, the bottle now only contained two tablets. Staff #1 gave one tablet to Tenant #2 on 2-25-12 and one tablet on Sunday 2-26-12, leaving a note for the registered nurse to reorder the medication on Monday 2-27-12. The registered nurse noted at that time the discrepancy between the amounts of Vicodin documented as used by Tenant #2 and the amount of Vicodin in the bottle. The monitors noted at least 20 staff members had access to Tenant #2's locked medication cupboard and the bottle of Vicodin between 2-16-12 and 2-25-12.

The monitors identified five other tenants who took Vicodin in February 2012. The monitors reviewed the clinical records, MARs and pharmacy delivery of the Vicodin for all five tenants. The monitors were able to reconcile the Vicodin for all five tenants, noting no discrepancies between Vicodin delivered to the program, Vicodin used by the tenants and Vicodin remaining unused.

The program did complete a count of Schedule II narcotics in February 2012; however, did not count other narcotics, such as Vicodin. Upon discovering Tenant #2's medication discrepancy on 2-27-12, the program moved all narcotics used by tenants and administered by staff to a locked cupboard in the nursing office. Only one key is available for the narcotic cupboard. Each staff member who is administering medications is required to sign the key out each time he/she needs to take a narcotic from the cupboard for administration and a shift count of all narcotics is now being done using one staff member from the off-going shift and one staff member from the on-coming shift to assure the appropriate number of tablets remain for each tenant using narcotics. There had been no further medication discrepancies noted by the program since initiation of the new procedures.

The monitors were unable to determine who may have taken the Vicodin as too many staff members had access to Tenant #2's medications. The program completed a timely investigation and reported the missing medications to the Department of Inspections and Appeals upon becoming aware of the medication discrepancy.

- Regulatory Insufficiency: None noted.

During the course of the recertification monitoring visit. the monitors identified the following

B. Life Safety

- Monitoring Observation: The program had an alarm system connected to the two doors which exited into an unsecured courtyard outside of the memory care unit. The doors had an egress bar on the doors which, when pushed, sounded an audible alarm. The alarm system had a coded keypad that staff members could enter a code to disenable the alarm temporarily when the door was opened but would reengage immediately when the door closed. This allowed staff members to enter the courtyard and reenter the building without setting off the alarm system. Each door also had a key slot that could be accessed with a key to completely disable the door's system, allowing the door to be opened and closed multiple times without setting off the alarm. The alarm system would not reengage without resetting with the key.

  On 8-15-12 at approximately 8:30 AM, the monitor, while accompanied by the Administrator, observed one of the doors leading to the courtyard to be non-functioning. The program routinely deactivated the door alarm to one of the doors leading to the outside courtyard by turning it off with the key whenever one tenant wished to go outside to sit while unsupervised by staff members. The tenant had mild dementia and no history of wandering or elopement attempts.
  The tenant lived in the secured memory care unit due to an anxiety condition which was lessened when residing in a smaller more intimate section of the program.
  A staff member reported the alarm had inadvertently not been reactivated earlier in the morning when the tenant had come back inside, leaving the courtyard unsupervised and available to all tenants residing in the memory care unit.

  When either door to the courtyard is deactivated in the manner as described above, all other tenants residing in the memory care unit have free access to the courtyard. The program had six tenants residing in the memory care unit who exhibited moderate to severe dementia and some who had a history of wandering or exit seeking behaviors. The courtyard, fence had an unsecured gate, which, when opened, lead to the front of the building, allowing access to a street running parallel to the building and surrounding residential neighborhoods.

  By leaving the door completely unalarmed, the program placed cognitively impaired tenants at risk for elopement from the program via the unsecured gait in the courtyard fence.

- Regulatory Insufficiency: An operating alarm system shall be connected to each exit door in a dementia-specific program. (IAC r. 481-69.32(2))