IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 41199-I

November 13, 2012

Ms. Nicole Ellermeier, Executive Director
Whispering Creek Assisted Living
2607 Nicklaus Blvd.
Sioux City, IA 51106

RE: Final Complaint/Incident Investigation Report – Whispering Creek Assisted Living, Sioux City, IA

Dear Ms. Ellermeier:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of October 31, 2012, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding 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
Final Complaint/Incident Investigation Report

Assisted Living Program: **Complaint/Incident Intake #: 41199-I**

Nicole Ellermeier, Executive Director
Whispering Creek Assisted Living
2607 Nicklaus Blvd
Sioux City, IA 51106

Date of Complaint/Incident Investigation:

October 31, 2012

Monitor(s):

Lori Miner, RN BSN
Joyce Kix, RN
James Berkley, RN BS

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:	18
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	24
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	12
Total Population of Program at time of on-site	12
TOTAL census of Assisted Living Program	36

Program History – There were regulatory insufficiencies found in the areas of Nurse Review, Evaluations and Medications during this certification period.

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

A. Medications

Complaint/Incident Allegation: The program reported Tenant #1 could not account for four tablets of Oxycontin.

- Monitoring Observation: Tenant #1, a 78 year-old, was admitted on 12-3-10 and had diagnoses of: History of Prostate, Skin, and Lung Cancer, Diabetes, Gout, Arthritis, Hypertension, and Chronic Pain. Tenant #1 had an intravenous port on the left chest. Tenant #1 also had a Urostomy. Tenant #1 had two errors on the cognitive ability assessment which rated Tenant #1 at low risk for cognitive impairment. Tenant #1 was admitted to hospice on 10-2-12 for lung cancer with secondary neoplasm of the bone. Service plans 10-3-12 through 10-27-12 identified Tenant #1 was independent with medication administration. Medications were noted to be stored in the bathroom of Tenant #1's apartment, except for narcotics which were to be stored in a lock box for which only Tenant #1 and the spouse had a key. The service plan of 10-27-12 noted Tenant #1 stored narcotics at his/her discretion, sometimes leaving them out on the bathroom counter. The hospice care report dated 10-11-12 identified extended release morphine, hydrocodone, and oxycodone as the narcotic medications prescribed for Tenant #1. Service plans 10-3-12 through 10-27-12 noted that Tenant #1 required assistance with bathing and dressing.

Tenant #1 shared the apartment with a spouse, Tenant #2. Tenant #2, a 78 year-old, was admitted on 12-3-10 and had diagnoses of: Diabetes, Macular Degeneration, Paralysis Agitans, Congestive Heart Failure, and Chronic Airway Obstruction. Tenant #2 had no errors on the cognitive assessment which rated Tenant #2 at low risk for cognitive impairment. Tenant #2 was admitted to hospice on 1-20-12 with Paralysis Agitans. Service plans 9-24-12 through 10-27-12 identified Tenant #2 as receiving outside assistance with medications. Medications were set up in advance by hospice, and the spouse, Tenant #1, assisted Tenant #2 with medications although it was noted Tenant #2 was able to take medications independently in the absence of Tenant #1. The hospice care report dated 9-20-12 identified oxycontin and Lortabs as the narcotic medications prescribed for Tenant #2. Service plans 9-24-12 through 10-27-12 noted Tenant #2 required the assist of one for mobility and transfer, had hospice assist with bathing, and required assistance with dressing and toileting.

An incident report dated 9-20-12 revealed Tenant #1 reported 33 missing hydrocodone and 86 missing oxycodone. Tenant #1 reported on 9-7-12 the prescriptions were filled and the prescriptions were stored on a lockbox in the apartment. Tenant #1 carried a key to the lockbox; Tenant #2 kept a key hanging inside the medicine cabinet in Tenant #2's bathroom. Tenant #1 reported keeping "several" tablets of each medication in a pill carrier in a pocket. Tenant #1 reported last taking medications from the lockbox on 9-18-12 and could not say whether or not the bottles were full, empty, or missing medications until 9-20-12. Tenant #1 refused to file a police report.

An incident report dated 9-20-12 revealed Tenant #2 reported four hydrocodone and two oxycontin tablets missing. The incident report documented morning pills were stored in a medication planner on the back of the toilet in Tenant #2's bathroom. Hospice was noted to have left four tablets of oxycontin out for evening doses on 9-17-12 and on 9-19-12 the remaining doses were missing. Hospice was noted to have left nine hydrocodone out for the tenant to take and five were accounted for, leaving four missing. Hospice documentation included a conversation with an adult child who thought Tenant #2 seemed groggy, and may have taken extra oxycontin.

On 10-3-12 a hospice note documented Tenant #1 reported missing four oxycontin tablets. Tenant #1 refused to store medications in the lockbox. The note also documented Tenant #1 had erratic behaviors and some confusion. Tenant #1 also made conflicting reports of what medications and how many were taken. At the time the medications were missing, Tenant #1 reported the medications were on the counter in Tenant #1's bathroom. Program documentation noted the medications were not being stored according to the plan. There was also concern Tenant #1 was not administering medications safely. The program reported Tenant #1 refused assistance with medication administration.

On 10-11-12 the hospice nurse documented during a visit Tenant #1 had a bottle of hydrocodone and oxycontin on the bathroom counter. Tenant #1 reported putting oxycodone pills in the oxycontin bottle but did not change the label.

On 10-15-12, the Licensed Practical Nurse (LPN) documented finding two small white pills on the floor in Tenant #1's bedroom. The pills fit the description of oxycodone.

Tenant #1 was admitted to the hospital for confusion after being found on the floor on 10-29-12. In an interview with the hospice nurse, she stated she understood Tenant #1 was over-medicated and it resulted in the hospitalization on 10-29-12.

Staff #1, Certified Nursing Assistant, was interviewed and stated she was not aware of any missing medications. Staff #1 stated Tenant #1 seemed "out of it" before he went to the hospital. Staff #2, Certified Medication Aide, stated Tenant #1 had not been his/her usual self and had been confused. Staff #2 reported seeing medications in Tenant #1's bathroom. Staff #2 was not aware of any missing medications.

The Program Nurse was interviewed and stated several attempts had been made to offer assistance with medication storage and administration, and Tenant #1 refused.

A family member, the adult child of Tenant #1 and #2, was interviewed. The family member stated there have been three episodes of missing pill from Tenant #1's apartment: about the first week of August 2012, September 2012, and October 2012. The family member stated for the last two episodes Tenant #1 had been more confused and could not say that the pills were not accidentally taken by Tenant #1. The family had set up a surveillance camera about a month ago. The camera was up for about two weeks, and the family member reported no evidence of theft showed up on the surveillance camera.

The hospice nurse stated Tenants #1 and #2 were reluctant to have persons take over their medications. She reported Tenant #1 had severe pain that was not managed well and recently spoke with a pharmacist in an attempt to better obtain pharmacological control of the pain. The hospice nurse noted Tenant #1 was groggy on 10-26-12 and required three "as needed" pills for breakthrough pain. The hospice nurse reported Tenant #1 had confusion and forgetful, erratic behavior. The hospice nurse did not believe anything would be found on the surveillance camera. A lockbox was initiated for Tenant #2 in May 2012, and for Tenant #1 in September 2012. Prior to starting hospice, Tenant #1 ordered large quantities of pills every two weeks.

The hospice nurse stated Tenant #1 would be returning to the program on the day of the onsite visit, 10-31-12. It was reported Tenant #1 had agreed to let hospice manage medications. Medication bottles would be locked and only hospice would have the key to the lockbox.

Tenant #1 and #2's apartment was viewed. Medications were in a filled med planner on the back of the toilet. Tenant #1's bedroom and bathroom had medications scattered throughout. According to the LPN, all care staff and housekeeping have a key to the room. Hospice staff also provide service and would have access to the medications..

Tenants #1 and #2, who resided in the same apartment as a married couple, reported missing narcotics on more than one occasion. Tenant #1 self-administered medications and Tenant #2 self-administered medications with the assistance of Tenant #1 after pills were set up by hospice. The family installed a surveillance camera for two weeks, with no suspicious activity noted. Tenant #1 was noted to have increasing confusion. Attempts to provide medication assistance were documented, but Tenant #1 refused.

Tenant #1 was hospitalized on 10-29-12 and over-medication played a role in the hospitalization. Tenant #1 was reported to have accepted medication assistance from hospice. Hospice was to set up medications in planners with medication bottles placed in lockboxes to which only hospice had a key.

The program identified Tenant #3 and #4 as also receiving narcotics. A review of the clinical records indicated Tenants #3 and #4 also self-administered medications. There were no known discrepancies with the narcotics for Tenants #3 and #4.

- Regulatory Insufficiency: None noted.