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 #:
43387-C

May 29, 2013

Ms. Angela Eppert, RN/Coordinator
Courtyard Terrace
713 W. 3rd Street
Boone, IA 50036

RE: Final Complaint/Incident Investigation Report, Courtyard Terrace, Boone, Iowa

Dear Ms. Eppert:

Enclosed is the **Final 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 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.

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
Final Complaint/Incident Investigation Report

Assisted Living Program:

Angela Eppert, RN/Coordinator
Courtyard Terrace
713 W. 3rd St.
Boone, Iowa 50036

Complaint/Incident Intake #:

43387-C

Date of Complaint/Incident Investigation:

April 24 and 25, 2013

Monitor(s):

Maribeth Freland 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:	33
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	33
TOTAL census of Assisted Living Program	33

Program History – The program received a regulatory insufficiency in the area of Transportation during the July 5, 2011 Recertification on-site.

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

A. Medications

Complaint/Incident Allegation: It was alleged tenant medications were not always charted when administered. It was alleged tenant medications were not always correctly set up in weekly medication planners. It was alleged one tenant was in extreme pain and did not receive pain medications in a way to effectively relieve the pain for two weeks, resulting in the tenant's hospitalization and subsequent death. It was alleged tenant narcotic medications were being stolen by staff members.

- Monitoring Observation: The program reported staff members administered medications or pre-filled medication planners for 16 current tenants. The program reported three of the sixteen tenants who received staff member administration of medications, Tenants #1, #2 and #3, used narcotic medications.

  During interview, the Registered Nurse (RN)/Coordinator reported each of the 16 tenants' medications, including narcotic medications, were stored in a locked drawer located in each tenants' apartment. The Coordinator reported either she or Staff #1, certified medication assistant (CMA), pre-filled each of the 16 tenants' weekly medication planner every Thursday morning. Of the sixteen tenants, two took the medications independently after staff members pre-filled the medication planners and one required daily reminders to take the medication but then did so independently. The RN/Coordinator reported all direct care workers and the Coordinator herself carried a master key that would open all tenants' medication drawers.

  During interview, the RN/Coordinator reported staff members initialed each individual medication on the Medication Administration Records (MARs) following

administration of each medication. Each staff member also initialed each tenant's Service Checklist when the medication administration was complete.

The monitor reviewed the Medication Administration Records for February, March and April 2013, finding the following discrepancies:

Tenant #	Medication	Dosage/Frequency	Error
Tenant #1	Debrox ear drops	4-5 drops twice daily for 5 days every month.	Transcribed for March 1-5: Administered at 8:00 a.m. March 1-28 and 8:00 p.m. March 1-14.
Tenant #1	Clobetasol Cream	0.05 % twice daily for 2 weeks beginning 3-1-13.	Transcribed for April 1-14: Not signed as applied at 8:00 a.m. on 4-14-13
Tenant #2	Aspirin	325 milligram (mg) daily.	Not signed as administered on 3-31-13.
Tenant #2	Namenda	10 mg twice daily.	Not signed as administered on 4-19, 20-13.
Tenant #3	Hydrocodone/APAP	5 mg/325 mg 1 to 2 tablets every 4 hours	Given 3-24-13 at 5:35 p.m., 7:35 p.m., 10:15 p.m.- less than 4 hours between doses. Given 3-27-13 at 4:00 p.m. and 7:30 p.m.- less than 4 hours between doses.
Tenant #4	Miralax	17 grams (gm) daily	Not signed as administered on 3-19-13.
Tenant #4	Vitamin D	5,000 IU one on Mon. and on Thurs.	Not signed as administered on Thurs. 4-4-13 and Mon. 4-22-13.
Tenant #9	Lorazepam	0.5 mg twice daily as needed for anxiety- at least 8 hours apart.	Given on 2-9-13 at 9:30 p.m. and again on 2-10-13 at 3:20 a.m.- only 6 hours apart.

The April 2013 MARs for Tenant #8 lacked staff member initials on the MAR and the Service Checklist indicating administration of all 8:00 a.m. medications on 4-5-13. The April 2013 MARs for Tenants #1, #2, #3, #4, #7 and #8 lacked staff member initials on the MAR and the Service Checklist indicating administration of all 8:00 a.m. medications on 4-13-13.

The monitor compared the medications pre-filled in Tenant #1, #2, #3, #7 and #8's apartment. The medications remaining in the morning, noon and/or evening slots for Wednesday 4-24-13 and Thursday 4-25-13 matched physician's orders with no discrepancies noted. During interview, Tenants #1, #2, #3 and #4, all tenants who have medication set up and administration by program staff members, reported noting

no concerns with inaccurate medication set up. During interview, Tenant #5 reported Staff #1, CMA, pre-filled his/her medication planner in January 2013 and inadvertently omitted one medication from the planner. Tenant #5 noted the discrepancy and immediately notified the CMA. The medication was added to the planner with no medication doses missed. Tenant #5 reported this occurred only once and had noted no other medication errors since.

The program reported discharging only one tenant in the previous four month period, Tenant #9. Tenant #9 was transported to the hospital and died prior to return to the program. Tenant #9, a 99 year old, was admitted to the program on 11-22-10 with the diagnoses of: Hypertension (HTN), Coronary Artery Disease, Anemia and Myelodysplastic Syndrome, a blood disorder. Tenant #9 answered all but two questions correctly on the Short Portable Mental Status Questionnaire (SPMSQ) completed on 6-11-12, indicating intact intellectual functioning. Tenant #9 received packed red blood cells on a routine basis beginning in December secondary to critical hemoglobin and hematocrit laboratory levels. Tenant #9 received transfusions on 12-11-12, 12-19-12, 1-22-13, 1-29-13, 2-6-13, 2-12-13 and 2-27-13.

Tenant #9 used Hydrocodone/APAP for discomfort on an as needed basis. Tenant #9 had not been using the Hydrocone/APAP due to effective pain relief when using Tylenol 650 mg four times daily. Tenant #9's physician discontinued the Hydrocodone/APAP on 2-15-13. Tenant #9's clinical record lacked any documentation of pain from 2-15-13 to 2-26-13.

On 2-26-13 Tenant #9 began complaining of abdominal discomfort. Staff members noted Tenant #9's abdomen was extended and firm. Tenant #9 denied nausea and vomiting. Tenant #9 had two large bowel movements during the evening of 2-26-13.

On 2-27-13 Tenant #9 went out for his/her blood transfusion and returned to the program. Upon return from the transfusion, the RN/Coordinator noted Tenant #9's abdomen to be distended and firm. Tenant #9 was congested with expiratory wheezes and dyspneic at rest. Tenant #9's legs were swollen to mid-calf. The RN/Coordinator contacted the physician, who ordered Lasix 20 mg to be given once.

On 2-28-13, the RN/Coordinator found Tenant #9 sitting in a chair, dyspneic with audible wheezes noted. Tenant #9 reported the abdominal discomfort had been lessening. Staff members noted Tenant #9's abdomen to be soft and non-tender. Tenant #9's legs continued to be swollen extending up to the knees. Tenant #9 held his/her abdomen with ambulation and grimaced in pain. The RN/Coordinator contacted Tenant #9's family member to transport Tenant #9 to the local emergency room. Tenant #9 was subsequently admitted to the hospital on 2-28-13 with a reported poor prognosis. Tenant #9 died on 3-6-13 while he/she remained hospitalized.

Tenant #9 lacked documentation indicating he/she experienced pain from 2-15-13 to 2-26-13. On 2-26-13 Tenant #9 began to experience abdominal pain that continued into 2-27-13. The program RN notified the physician related to the pain when things failed to improve. Per the physician order the RN sent Tenant #9 to the emergency room for medical evaluation. Tenant #9 was admitted to the hospital due to cardiac and blood disorder issues and died while hospitalized.

During interview, the RN/Coordinator reported all narcotics were counted once weekly by the Coordinator or Staff #1, CMA, when completing the weekly pre-fill of the medication planners. The Coordinator reported the narcotics were not counted at shift change.

Tenant #1, an 85 year old, was admitted to the program on 9-5-10 with diagnoses of: Severe Osteoarthritis; Degenerative Joint Disease with Avascular Necrosis to the Right Hip Joint; Insulin Dependent Diabetes and Hypertension. Tenant #1 answered all but three questions correctly on the SPMSQ completed on 4-9-13, indicating mild intellectual impairment. Tenant #1 began experiencing increased pain to the right hip in early February 2013. During interview, Tenant #1 reported he/she needed to have the right hip replaced; however, the physician was waiting until other physical issues cleared before doing the surgery. Tenant #1 reported the physician prescribed Hydrocodone/ APAP for the pain and, after multiple changes to the dosage and frequency, the medication was effective with taking the edge off of the pain if taken in a dosage of two tablets four times daily.

Tenant #1's clinical record included a physician's order, dated 2-5-13, initiating the Hydrocodone 5 mg/325 mg 1 to 2 tablets four times daily as needed. According to pharmacy records, 240 tablets of Hydrocodone 5 mg/ 325 mg tablets were delivered to the program on 3-5-13.

The narcotics record indicated the CMA counted 182 Hydrocodone/APAP tablets remained in the bottle on 3-14-13. The narcotics record documented 30 tablets were administered between 3-14-13 and 3-21-13. On 3-21-13 the CMA counted 127 tablets of Hydrocodone/APAP remained in the bottle. During reconciliation of the narcotic medication, the monitor noted 25 tablets unaccounted for.

The narcotics record documented 28 tablets were administered between 3-21-13 and 3-28-13. On 3-28-13 the CMA counted 70 tablets of Hydrocodone/APAP remained in the bottle. During reconciliation of the narcotic medication, the monitor noted 29 tablets unaccounted for.

The narcotics record documented 28 tablets were administered between 3-28-13 and 4-4-13. On 4-4-13 the CMA counted 23 tablets of Hydrocodone/APAP remained in the bottle. During reconciliation of the narcotic medication, the monitor noted 19 tablets unaccounted for.

According to pharmacy records, 240 tablets of Hydrocodone/APAP 5 mg/325 mg tablets were delivered to the program on 4-8-13. The narcotics record documented 22 tablets were administered between 4-4-13 and 4-9-13. On 4-9-13 the CMA counted 240 tablets of Hydrocodone/APAP remained after the delivery. During reconciliation of the narcotic medication, the monitor noted 1 tablet unaccounted for.

The narcotics record documented 30 tablets were administered between 4-9-13 and 4-18-13. On 4-18-13 the CMA counted 183 tablets of Hydrocodone/APAP remained in the bottle. During reconciliation of the narcotic medication, the monitor noted 27 tablets unaccounted for.

The CMA counted the tablets once weekly but did not reconcile the medication counts to determine the amount of medications that should remain based on the amount dispensed from the pharmacy and the amounts administered by staff members. The RN/Coordinator also did not reconcile Tenant #1's Hydrocodone/APAP tablets to assure misappropriation had not occurred.

The monitor could not determine if the medications unaccounted for had been stolen or if the staff members had not documented each time the narcotics had been removed from the bottle and given to Tenant #1 as the system used by the program for counting narcotics did not allow for accurate reconciliation of the medication in a timely manner.

Tenant #3, an 87 year old, was admitted to the program on 9-28-11 with diagnoses of: Chronic Low Back Pain; HTN; Degenerative Arthritis; Spinal Stenosis and Lumbar Radiculopathy. Tenant #1 was hospitalized on 3-14-13 for a knee replacement and returned to the program on 3-22-13. Tenant #3 answered all but one question correctly on the SPMSQ completed on 3-22-13, indicating intact intellectual functioning.

Tenant #3's clinical record included a physician's order, dated 3-22-13, initiating the Hydrocodone 5 mg/325 mg 1 to 2 tablets every four hours as needed. According to pharmacy records, 40 tablets of Hydrocodone 5 mg/ 325 mg tablets were delivered to the program on 3-22-13 and another 40 tablets on 3-26-13.

The narcotics record documented 43 tablets were administered between 3-22-13 and 3-28-13. On 3-28-13 the CMA counted 34 tablets of Hydrocodone/APAP remained in the bottle. During reconciliation of the narcotic medication, the monitor noted 3 tablets unaccounted for.

The narcotics record documented 28 tablets were administered between 3-28-13 and 4-2-13. On 4-3-13 the RN/Coordinator counted 1 tablet of Hydrocodone/APAP remained in the bottle. During reconciliation of the narcotic medication, the monitor noted 5 tablets unaccounted for.

According to pharmacy records, 40 tablets of Hydrocodone/APAP 5 mg/325 mg tablets were delivered to the program on 4-2-13. On 4-3-13 the RN/Coordinator counted 41 tablets of Hydrocodone/APAP remained after the delivery. Tenant #3 did not take any more Hydrocodone/APAP after 4-1-13. During reconciliation of the narcotic medication, the monitor noted all 41 tablets remained on 4-24-13.

The CMA and/or RN/Coordinator counted the tablets once weekly but did not reconcile the medication counts to determine the amount of medications that should remain based on the amount dispensed from the pharmacy and the amounts administered by staff members to assure misappropriation of the narcotic had not occurred.

The monitor could not determine if the medications unaccounted for had been stolen or if the staff members had not documented each time the narcotics had been removed from the bottle and given to Tenant #3 as the system used by the program for

counting narcotics did not allow for accurate reconciliation of the medication in a timely manner.

- Regulatory Insufficiency: When medications are administered traditionally by the program, the administration of medications shall be provided by a registered nurse, a licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6)a)

- Regulatory Insufficiency: Narcotics protocol shall be determined by the program's registered nurse. (IAC r. 481-67.5(7))

B. Tenant Rights

Complaint/Incident Allegation: It was alleged multiple tenants expressed unhappiness with the way staff members treated them. It was alleged one tenant felt discriminated against when his/her financial means changed, requiring use of a state funded program to pay for services.

- Monitoring Observation: The monitor interviewed Tenants #1, #2, #3, #4, #5 and #6. All six tenants reported staff members were kind and helpful. Tenants #1, #2, #3, #4, and #5 denied feeling threatened or treated rudely by staff members. Tenant #6 reported feeling billing personnel were not helpful when assisting Tenant #6 with filling out paperwork for a Title XIX program. Tenant #1 indicated he/she felt slightly threatened when first using a state funded program to pay for services at the program as Tenant #6 was told he/she may need to move to a smaller apartment. Tenant #6 reported he/she was never made to move to a smaller apartment.

  Tenants #4, #5 and #6 reported the RN/Coordinator was not as social as previous Coordinators. All three tenants felt the RN/Coordinator was too young and inexperienced to hold the position of Coordinator.

- Regulatory Insufficiency: None noted.

C. Life Safety

Complaint/Incident Allegation: It was alleged the program had mold in tenant apartments and did not remove the mold appropriately.

- Monitoring Observation: On 4-23-13, the monitor toured the common areas of the program noting the areas to be clean, odor free and home-like in appearance. The walls were wallpapered with no observable mold noted. The ceilings were painted with no observable mold noted. The monitor toured the apartments of Tenants #1, #2, #3, #4, #5, #6, #7 and #8 noting all walls and ceilings were painted with no observable mold noted. The tub surround in each apartment appeared clean and mold free. During interview, Tenant #6 reported approximately one year ago he/she noted mold growing at the top of the wall close to the ceiling in Tenant #6's bedroom and

bathroom. Tenant #6 reported the housekeeper cleaned the areas with a solution that removed the mold and Tenant #6 had never noted any further mold in the apartment.

- Regulatory Insufficiency: None noted.

D. Other

Complaint/Incident Allegation: It was alleged the program staff took money and gifts from tenants.

- Monitoring Observation: The monitor interviewed Tenants #1, #2, #3, #4, #5 and #6, all cognitively intact tenants. All six tenants reported staff members had never asked for money or gifts. Tenants #2 and #3 both reported at Christmas time they at times gave a small token gift to staff members but did so voluntarily. Tenant #4 reported some tenants got together and purchased small gifts for staff members but participation had always been voluntary.

- Regulatory Insufficiency: None noted.