IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 43910-C

June 26, 2013

Ms. Robbie Hinz, RN Director
Prairie Hills at Tipton
219 South Cedar Street
Tipton, IA 52772

RE: Final Complaint/Incident Investigation Report – Prairie Hills at Tipton, Tipton, IA

Dear Ms. Hinz:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of May 29, 2013, 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 #:** 43910-C

Robbie Hinz, RN Director
Prairie Hills at Tipton
219 South Cedar Street
Tipton, IA 52772

Date of Complaint/Incident Investigation:

May 29, 2013

Monitor(s):

Margaret Kaltefleiter, RN MS

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:	30
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	30
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	4
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	8
TOTAL census of Assisted Living Program	38

Program History – The Program did not receive any regulatory insufficiencies 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: It was alleged a tenant ran out of insulin and another tenant's insulin was used.

- Monitoring Observation: Three tenant files (Tenants #1, #2 and #3) were reviewed. Tenants #1, #2, and #3 received insulin.

  Tenant #1, an 86 year old was admitted on 2-7-13 and diagnoses include: Arterial Embolism Stroke 10/12, Breast Cancer with Right Mastectomy, Cardiomyopathy, Congestive Heart Failure (CHF), Diabetes Mellitus Type II, Depression, Hyperlipidemia, Hypertension (HTN), Hypothyroidism, Macular Degeneration, Polyneuropathy, Restless Leg Syndrome and Vitamin D Deficiency. According to the service plan dated 3-7-13, staff would manage and administer all oral medications. Staff would monitor Tenant #1 performing own glucometer checks and insulin administration. Tenant #1 received Novolog insulin for self-injection before meals and at bedtime per sliding scale. Blood glucose was checked to determine the amount. According to the Medication Administration Record (MAR) at 8:00 p.m. on 5-5-13, Tenant #1's blood glucose was 215. Per the sliding scale, Tenant #1 needed 8 units for a blood glucose result between 210 and 229.

Tenant #2, an 87 year old was admitted on 8-22-11 and diagnoses include: CHF, Aortic Stenosis and Cataracts. According to the service plan dated 5-3-13, Tenant #2 took own medications from a planner which was set up by family. Tenant #2 did not receive medication administration assistance from the Program.

Tenant #3, an 82 year old was admitted on 1-26-13 and diagnoses include: Diabetes, Arthritis, HTN, Osteoporosis, Depression, Hypothyroidism and Cataracts. According to the service plan dated 2-17-13, Tenant #3 self-administered all oral medications as ordered by a physician. Medications were kept in a locked cupboard in Tenant #3's room. Staff would monitor glucometer checks and self-administration of insulin injections and notify physician of readings outside of parameters. Tenant #3 received Humulin 15 units every morning at 8:00 a.m. and 7 units every night at 5:00 p.m.

According to a Program Document dated 5-14-13, the Director received a phone call from Staff #1 on 5-5-13 at approximately 8:00 p.m. that Tenant #1 did not have enough Novolog insulin for the evening at bedtime dosage. Staff #1 checked Tenant #1's refrigerator and another Novolog pen was not available. The Director instructed Staff #1 to check with Tenant #2 to see if Tenant #2 had any new pens that had not yet been opened. Staff #1 talked to Tenant #2 who stated Tenant #2 had extra pens and was willing to loan a pen to the Program. Staff #1 removed an unopened Novolog pen from Tenant #2's refrigerator and took it to Tenant #1's apartment for Tenant #1's use. Tenant #1's new supply of Novolog pens was received the next day and one was removed from the box and given to Tenant #2 to replace the one taken the night before. A new system was initiated to prevent that from happening in the future. Supplies would be checked by the universal workers on Mondays and Thursdays to ensure there was enough to last until the next check day. All universal workers were trained on the system.

Staff #1 stated she had used another tenant's insulin for a different tenant. Within the last month at 8:00 p.m. Tenant #1 had an empty pen in the locked box. The process was to always keep a spare pen in the locked box in a bag with a label. She called the nurse on call who was the Director. The Director wanted to know which tenants had what type of insulin and then said she would call back. Staff #1 was asked if Tenant #2 took Novolog insulin. Staff #1 talked with Tenant #2 and verified Tenant #2's insulin was the same as Tenant #1's.

Staff #1 said using another tenant's insulin only occurred one time between Tenant #1 and Tenant #2. Borrowing insulin had never happened before and she had never found an empty insulin pen before. Staff #2 said she had never used someone else's insulin for a different tenant.

The Director stated she received a call from Staff #1 on a Sunday night stating Tenant #1 was out of insulin. She consulted with the Nurse. The Program had administered Tenant #2's medications in the past so the Director instructed Staff #1 to ask Tenant #2 if she could borrow a new, unopened pen and to compare the label. Tenant #2 agreed. Tenant #1 was not aware of the situation. The Director stated there was a pharmacy on call but she didn't call them as she knew it would be a two hour wait. Due to Tenant #1's blood sugar, she did not want to wait two hours. The Director stated this was the only time she had used someone else's insulin for a different tenant.

The Director stated using someone else's insulin for another tenant only occurred once and had never happened before and there had never previously been an empty pen.

The Nurse stated the Director called her and told her Tenant #1 was out of insulin and asked what could be done? The Nurse knew that Tenant #2 had Novolog insulin available. The Nurse stated there was a pharmacy on call and they used a pager system and would call right back. It would take one and one half to two hours for the pharmacy to deliver. The Nurse said using someone else's insulin for another tenant had never happened before. A system was currently in place where universal workers checked on Mondays and Thursdays and filled out a log if there were not enough supplies. Prior to the new system she relied on universal workers to notify her or the Director when reorders were needed.

According to a Pharmacy Primary Services Agreement, the pharmacy would provide any drug, biological or supply needed on an emergency basis in a prompt and timely manner. In the event the pharmacy could not furnish an ordered medication on a prompt and timely basis, the pharmacy would make arrangements with another pharmacy supplier in a community near the Program to provide such service to the Program if possible. The pharmacy would notify the Program of any such arrangement.

The Program provided a copy of a document dated 5-5-13 and signed by Tenant #2 that indicated Tenant #2 was asked by a staff member to borrow a new Novolog pen and one would be returned to Tenant #2 the next day. Tenant #2 gave permission for this and a new Novolog pen was returned to Tenant #2 on 5-6-13.

Tenant #1 stated Tenant #1 loved living at the Program. Staff treated Tenant #1 very well. Medications were always administered on time and were available when needed.

Tenant #2 stated staff was good and the food was okay. Tenant #2 remembered being asked if staff could borrow an insulin pen and that was okay with Tenant #2. Tenant #2 stated Tenant #2 knew sometimes in business decisions had to be made to get something done. Tenant #2 stated a replacement pen was received.

According to a Policy and Procedure for Medication Administration in an Emergency dated 5-13-13, in the event that a tenant ran out of a medicine or a medical supply, it was the Program's policy the Program did not borrow medicines or medical supplies from another tenant to administer to the tenant in need. In the event the Program was unable to obtain the medicine or medical supply from the pharmacy in a timely manner, the Program would call the tenant's physician immediately and/or call 911 emergency responders.

Review of tenant files, staff interviews, tenant interviews, review of Program documents and a review of a pharmacy contract was completed.

While a deviation from the requirements of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exits.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged a universal worker administered insulin.

- Monitoring Observation:

  A medication pass was observed on 5-29-13 at 5:00 p.m. for Tenant #3. Staff #3 used hand sanitizer and checked the MAR. She unlocked the cabinet and poured pills from a medication planner into a medication cup and handed the medication cup to Tenant #3. Staff #3 observed as Tenant #3 swallowed the medications. Tenant #3 received seven units of Humulin insulin at 5:00 p.m. Tenant #3 dialed up seven units and added a needle to the pen. Tenant #3 showed Staff #3 the insulin pen to verify the dose. Tenant #3 self-administered the insulin and disposed of the needle. Staff #3 documented the medications on the MAR including the site of the insulin injection. A spare pen was stored in the refrigerator in a locked box. The box held 220 units of insulin.

  A medication pass was observed on 5-29-13 for Tenant #1. Staff #3 used hand sanitizer and gloved. She checked the MAR and prepared the equipment for a blood glucose check. Tenant #1 performed the glucometer check independently. The result was 146 and per the sliding scale no insulin was needed. Additional Novolog insulin was observed in the refrigerator. Two pens with 250 units of insulin each were noted.

  Staff #1 stated she passed medications and assisted with insulin administration. The insulin administration procedure was to hand the pen to the tenant. Tenant #1 was on a sliding scale for insulin. Tenant #1 would complete a blood sugar check and then check the range sheet to determine the dose. Tenant #1 would turn the pen to the amount needed and then administer the insulin. At 5:00 p.m., Staff #1 would assist Tenant #3 with insulin. She would hand Tenant #3 a pen and Tenant #3 would turn it to seven units. Staff #1 would verify the dose and Tenant #3 would administer the insulin.

  Staff #2 stated she passed medications and assisted with insulin administration. Staff #2 said most tenants did insulin administration themselves and had an insulin pen. Blood sugar checks were completed and if necessary a sliding scale was followed. Tenants would flip the dial to the number of units needed and Staff #2 verified the amount.

  The Nurse stated usually the universal workers assisted with insulin administration. They observed the tenant and gave reminders if needed. They would remind the tenant which site was last used and observe the correct dose was dialed up.

  The Director stated if assisting with insulin administration, staff was delegated on the procedure. Staff would get the pen or syringe out and gave it to the tenant to put on the needle, dial the amount and double check against the MAR. The tenant did the injection. Syringes were locked in the refrigerator and the amount was verified.

According to a Medications policy, the Program would provide medication supervision by a registered nurse and maintain a medication record for each tenant. The Program would not prohibit a tenant from self-administering medications.

According to a Delegation Form for Assisting with Insulin Administration, universal workers could not actually inject insulin. However, they could assist the tenants with proper administration by: checking the MAR for the correct medication, dose, time, route; remove the proper prefilled syringe from the refrigerator, give the pre-filled insulin syringe with the proper dose to the tenant, help sanitize the injection site with an alcohol wipe; watch the tenant inject the insulin into any fatty tissue in the upper arm, thigh or abdomen; tenant needed to dispose of the used syringe into a sharps container.

According to a Delegation Form for Assisting with Insulin Pen Administration, universal workers could not actually inject insulin. However, they could assist the tenants with proper administration by: checking the MAR for the correct medication, dose, time, route; remove the proper pen from the refrigerator, give the pen to the tenant, have tenant place new needle on pen and dial up the proper dosage, verify dosage on MAR with what tenant had dialed up, help sanitize the injection site with an alcohol wipe; watch the tenant inject the insulin into any fatty tissue in the upper arm, thigh or abdomen; tenant needed to remove and dispose of the used needle into a sharps container and replace cap on pen.

Observation of a medication pass, staff interviews, review of the medication policy and review of insulin delegations indicated staff assisted with insulin administration, tenant's self-administered insulin and medications were available when needed.

- Regulatory Insufficiency: None noted.