IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 44991-I

October 3, 2013

Ms. Michelle Sides, Director
Sunnybrook of Muscatine
3515 Diana Queen Drive
Muscatine, IA 52761

RE: Final Complaint/Incident Investigation Report – Sunnybrook of Muscatine, Muscatine, IA

Dear Ms. Sides:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of September 24 & 25, 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:

Michelle Sides, Director
Sunnybrook of Muscatine
3515 Diana Queen Dr.
Muscatine, Iowa 52761

Complaint/Incident Intake #:

44991-I

Date of Complaint/Incident Investigation:

September 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:	43
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	45
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	12
Total Population of Program at time of on-site	14
TOTAL census of Assisted Living Program	59

Program History – The program received regulatory insufficiencies in the areas of Staffing, Reporting to the Department and Tenant Documents during this certification period.

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

Tenant Rights

Complaint/Incident Allegation: The program reported two tenants, Tenants #1 and #2, had Lorazepam (an antianxiety medication) missing from their apartments.

- Monitoring Observation: The program reported administering Lorazepam on a routine basis to four tenants and Lorazepam on an as needed basis to six tenants, including Tenants #1 and #2.

  According to the program policy, titled Narcotics or Medications of Concern Checking, a medication tracking sheet would be started with all schedule II narcotic medications. Two staff members, one from the on-coming and one from the out-going shift, were to count the medications being tracked at a minimum of every 24 hours with the shift to be defined by the program nurse. Any discrepancies were to be immediately reported to the nurse.

  During interview, the Program Director and the License Practical Nurse (LPN)/Dementia Coordinator reported each tenants' medications, including narcotic medications, were stored in a locked cupboard located in each tenants' apartment. Both reported delegated universal workers administered medications to program tenants.

All narcotics were counted daily at shift change collectively with one staff member from the first shift who had been administering medications during that shift and with one on-coming second shift staff member who would administer medications during the up-coming second shift. Both the Director and the LPN/Dementia Coordinator reported a narcotic count sheet was kept with the medication administration records in the apartment locked cupboard of each tenant who took narcotic medications. The shift change narcotic counts were to be documented on the narcotic count sheets. Each time a staff member administered a narcotic pill, either scheduled or on an as needed basis, the number of pills removed from the bubble pack and administered was to be subtracted from the previous narcotic count, totaled to document the number of remaining pills and documented on the narcotic count sheet. Both reported all direct care workers on each shift carried a master key that would open all tenants' medication cupboards.

According to the program's internal investigation, Staff #1 and Staff #2 counted narcotic medications on 7-16-13, noting Tenant #1 and Tenant #2's narcotic counts to be missing one pill each when compared with the previous narcotic count. The program was unable to determine why Tenant #1 and Tenant #2's narcotic counts were not accurate.

According to the program's schedules, 11 universal workers carried the master key to tenant medication cabinets between the time when the narcotics were counted by two staff members on 7-15-13 at first/second shift change and when the narcotics were counted on 7-16-13.

The monitor interviewed all staff members who were involved in the narcotic counts for Tenants #1 and #2 on 7-15-13, 7-16-13 and 7-17-13. During interview, Staff #1, #2 and #3 reported always counting the narcotics collectively with two staff members with both completing the count at the same time, comparing the count to the previous documented total and initialing the narcotic sheet at the same time. Staff #1 and #2 reported the counts were confusing for Tenant #1 due to error corrections on the narcotic sheet.

Tenant #1, a 94 year old, was admitted to the program on 9-22-12 and resided in the program's dedicated dementia unit. Tenant #1 had diagnoses of Memory Impairment and Depression. Tenant #1 scored a 4 on the Global Deterioration Scale (GDS) completed on 1-25-13 and 9-20-13, indicating moderate cognitive decline. Tenant #1 used Lorazepam for anxiety and agitation on both a scheduled and as needed basis. Tenant #1 took one 0.5 (milligram) mg tablet each evening and one-half of a 0.5 mg tablet of Lorazepam each morning on a scheduled basis. Tenant #1 also took Lorazepam one-half of a 0.5 mg tablet up to three times daily as needed for agitation. The program's previous registered nurse (RN) had two narcotic count sheets available for staff members to document Lorazepam use and shift counts, one for the 0.5 mg whole tablets and one for the half tablets used both for the scheduled dose and the as needed dose.

The narcotic sheets indicated one whole tablet of Lorazepam was administered at 8:00 p.m. on 7-15-13 but the tablet was inadvertently subtracted from the half tablet sheet making the half tablet count different than the actual amount in the bubble packs.

Four other errors occurred after the original error when staff members subtracted from the amount documented in error. Eventually the errors were identified and corrected by overwriting numbers to correct the amounts on the narcotic count sheet. The counts were hard to track following the error correction. The discrepancies were not immediately reported to the program nurse. The program issued discipline to the staff member who did not immediately report Tenant #1's Lorazepam discrepancy. During reconciliation of the narcotic medication, the monitor found one half 0.5 mg tablet unaccounted for. The monitor could not determine the reason for the missing tablet of Lorazepam.

Tenant #2, a 93 year old, was admitted to the program on 5-15-12 and resided in the program's dedicated dementia unit. Tenant #2 had diagnoses of Dementia, Hypertension, and Diabetes. Tenant #2 scored a 6 on the GDS completed on 5-13-13 and 8-8-13, indicating very severe cognitive decline. Tenant #2 used Lorazepam for anxiety and agitation on an as needed basis. Tenant #2 took one 0.5 mg tablet up to twice daily as needed.

During reconciliation of the narcotic medication, the monitor found one 0.5 mg tablet unaccounted for. The monitor could not determine the reason for the missing tablet of Lorazepam.

Staff members followed the program policies for documenting Tenant #1 and #2's Lorazepam use and completed shift counts daily as directed in the program's policy. The program disciplined the staff member who initially identified the discrepancy but did not immediately report this to the RN. Eleven staff members had access to Tenant #1 and #2's Lorazepam between 7-15-13 and 7-16-13 when the missing Lorazepam tablets were identified. The program completed an investigation into the missing Lorazepam tablets as required and initiated an in-service to review the process for narcotic counts/documentation. The current RN separated all scheduled and as needed medications onto separate narcotic count sheets to better identify discrepancies and to decrease the likelihood of staff members documenting inadvertently on the wrong sheet.

- Regulatory Insufficiency: None noted.