IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 45601-C

October 15, 2013

Ms. Bethany Clemenson, Executive Director
Windsor Manor Vinton
1807 West 5th Street
Vinton, IA 52349

RE: Final Complaint/Incident Investigation Report – Windsor Manor Vinton, Vinton, IA

Dear Ms. Clemenson:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of October 7 & 8, 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 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Bethany Clemenson, Executive Director
Windsor Manor Vinton
1807 West 5th Street
Vinton, IA 52349

Complaint/Incident Intake #: 45601-C

Date of Complaint/Incident Investigation:

October 7 & 8, 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:	22
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	25
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	8
TOTAL census of Assisted Living Program	33

Program History – The Program has not received any regulatory insufficiencies during this certification period.

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

A. Staffing

Complaint/Incident Allegation: It was alleged a tenant had a high blood sugar and a nurse wanted to administer fast acting insulin.

- Monitoring Observation: Six tenant files (Tenants #1, #2, #3, #4, #5, and #6) were reviewed. Tenants #1, #2, #3 and #4 were diabetic and received Program administered insulin.

  Tenant #1, a 78 year old, was admitted on 7-2-07 and diagnoses included: Schizophrenia, Insulin Dependent Diabetes Mellitus (IDDM), Hypothyroid and Hypertension (HTN). Tenant #1 was staged at a four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. According to a service plan dated 6-26-13, Tenant #1 was diabetic and used insulin and oral medications. Staff assisted with medication administration. Insulin was provided in dosing pens. Blood sugars were checked per doctor's orders. According to the Medication Administration Record (MAR), Tenant #1 received Novolog Flexpen Syringe; inject five units subcutaneous (SQ) before each meal. Tenant #1 received Lantus Solostar 100 units; inject 50 units SQ at bedtime. Tenant #1 had a fingertip blood sugar test three times weekly: Monday, Wednesday and Friday, at varying times. Notify the nurse if the blood sugar was greater than 300. A review of Tenant #1's MARs for

August, September and October did not indicate any blood sugar results exceeding 300.

Tenant #2, an 86 year old, was admitted on 8-12-13 and diagnoses included: IDDM, HTN, Renal Failure and Anxiety. Tenant #2 was staged at a three on the GDS which indicated mild cognitive decline. According to an initial service plan dated 8-9-13, Tenant #2 was a newly diagnosed insulin dependent diabetic. Tenant #2 requested assistance with administering medications and insulin. Staff assisted with checking blood sugars and recording them on the MAR. According to physician orders dated 8-12-13, Tenant #2 received Humalog 100u/ml SQ suspension 5 units 3 times daily before meals, Lantus 100u/ml SQ 16 units daily and 16 units at bedtime. Fingertip blood sugar was checked four times daily and to notify nurse if greater than 300 or less than 60. A Physician's Report/Orders document dated 8-22-13 indicated an increase of Humolog 7 units before supper and 5 units before breakfast and lunch. A review of the August MARs indicated the following blood sugar results exceeded 300: 8-25-13 at bedtime was 300, 8-26-13 at bedtime was 303, and 8-29-13 at bedtime was 410. The nurse was notified of the results. Tenant #2 was hospitalized from 8-30-13 through 9-11-13. Upon discharge, orders were received for Lantus insulin 100u/ml 16 units into the skin 2 times daily, Humalog insulin 100u/ml inject 2-8 units into the skin 4 times daily before meals and nightly, Humalog insulin 100u/ml inject 6 units into the skin 2 times daily before meals and inject 7 units into the skin daily before supper. A Physician Order Sheet dated 9-16-13 indicated Novolog Flexpen Syringe, inject 5 units SQ before breakfast and lunch and inject 7 units before supper and Lantus Solostar 100 u/ml inject 16 units SQ every 12 hours. Fingertip blood sugar was checked four times daily and to notify the nurse if less than 60 or greater than 300. A review of the September MARs indicated on 9-13-13 at 4:00 p.m. the blood sugar was 350 and the nurse was notified. A review of Tenant #2's October MARs did not indicate any blood sugar results exceeding 300.

Tenant #3, an 84 year old, was admitted on 9-5-10 and diagnoses included: IDDM, HTN, Anemia, Chronic Renal Failure and History of Non-Healing Wounds on Lower Extremities. Tenant #3 was discharged from the Program on 9-3-13. According to a service plan dated 8-16-13, Tenant #3 requested the nurse fill the medication box and Tenant #3 would take scheduled medications as set up. Tenant #3 requested assistance when taking pain medication. Staff to administer as needed pain medications as requested by Tenant #3. Tenant #3 requested assistance with administering insulin twice daily and with checking blood sugars four times a day. Tenant #3 had a history of developing low blood sugar, reported usually getting sweaty and some vision changes. Orange juice was in the apartment for those symptoms. The Program started administration of insulin and blood sugar checks on 8-16-13. According to the August MARs, Tenant #3 received Humalin insulin 70/30, 15 units every morning and 8 units every evening. Fingertip blood sugars were checked four times a day and to notify the nurse if less than 60 or greater than 300. A review of the August MARs indicated the following blood sugar results exceeded 300: 8-24-13 at 4:00 p.m. was 463 and at 8:00 p.m. was 575, on 8-25-13 at 4:00 p.m. was 372 and at 8:00 p.m. was 375. The nurse was notified of the blood sugar results.

According to the Nurse's Notes dated 8-24-13 at 7:15 p.m., the Nurse was notified that Tenant #3's fingertip blood sugar was 575. The Emergency Room (ER) physician was updated and orders received to give 10 units of Humalog and monitor

every 30 minutes times four or have Tenant #3 come to the ER. The pharmacist on call was notified for delivery of Humalog. At 7:40 p.m. Tenant #3's family was updated and wanted Tenant #3 evaluated at the ER. Tenant #3 was transported via a Program bus. At 11:30 p.m. Tenant #3 was discharged back to the Program and the Nurse transported. The diagnosis was Urinary Tract Infection (UTI) which caused the elevated fingertip blood sugar. A new order was received for Bactrim DS one half tab four times a day. The medication box was filled with two pills from the ER. The RN faxed the pharmacy. No changes to the insulin orders. Pharmacy records indicated 10 units of Novolog Flexpen was delivered for immediate administration. The medication was not administered. A Pharmacy document showed the Novolog Flexpen syringe was returned to the pharmacy and there was no charge to Tenant #3.

Staff #3 stated she took the fingertip blood sugar for Tenant #3 and the result was 575. She called the Nurse who contacted the ER to get an order. Staff #3 stated Tenant #3's family wanted Tenant #3 to go to the ER so the insulin dose was not given per the Nurse's direction.

The Nurse stated the Universal Worker called her and said Tenant #3's blood sugar was 575 so she called the ER physician. The physician asked what could cause this and she couldn't think of anything as there had been no change in diet and Tenant #3 had no complaints. The physician gave two options: Have Tenant #3 come to the ER and they would treat or if the Nurse was comfortable, she could give a Humalog dose and watch Tenant #3 while the blood sugar came down, plus do frequent blood sugar checks. The Nurse stated she would be comfortable doing that but needed to check with Tenant #3's family. She contacted the family and they wanted Tenant #3 taken to the ER. The Executive Director (ED) came in and took Tenant #3 to the ER. Tenant #3 had a UTI and was started on an antibiotic. The Nurse brought Tenant #3 back around 11:30 p.m. and set up the medication box with the new antibiotic. Tenant #3's blood sugars evened out right away.

Tenant #4, an 85 year old, was admitted on 8-24-10 and diagnoses included: Dementia, Depression, HTN, IDDM, Hyperlipidemia and a History of UTI's. Tenant #4 was staged at a five on the GDS which indicated moderate severe cognitive decline. According to an annual service plan dated 8-23-13, Tenant #4 had blood sugar checks daily. Staff obtained the blood sugar and recorded on the MAR. The physician reviewed the blood sugars on rounds. Tenant #4 received insulin daily and requested that staff drew up the correct dose and administered as directed. According to the MARs, Tenant #4 received Lantus 10 units SQ every evening. Fingertip blood sugars were checked four times daily and to notify the nurse if less than 60 or greater than 300. A review of the August MARs indicated the following blood sugar results exceeded 300: 8-6-13 at 4:00 p.m. was 337, 8-13-13 at 4:00 p.m. was 305, 8-14-13 at 8:00 p.m. was 314, 8-24-13 at 11:00 a.m. was 373 and on 8-29-13 at 10:30 a.m. was 316. The nurse was notified of the results. According to the September MARs, the following blood sugar results exceeded 300: 9-13-13 at 4:00 p.m. was 313 and 9-16-13 at 1:00 p.m. was 301 and the nurse was notified. According to the October MARs the blood sugar exceeded 300 on 10-6-13 at 10:30 a.m., was 331 and the nurse was notified.

Staff #1 stated if a tenant had an elevated blood sugar she would notify the nurse, push water and if needed, the nurse would come in to handle it. This usually

happened with tenants who just ate breakfast or an afternoon snack. She would recheck the blood sugar every 30 minutes afterwards to make sure it was going down. Staff #2 stated if a tenant had an elevated blood sugar she would check every hour, give water and notify the nurse. Staff #3 stated she would call the nurse and the nurse would call for an order or call an ambulance and send the tenant out. She would do follow up checks to make sure the blood sugar was coming down. The Nurse stated staff had parameters (nursing parameters) if the blood sugar was less than 60 or greater than 300 to call the nurse on call. Once they called they documented the call on the back of the MAR. Nursing judgment dictated what happened next. The ED stated if a tenant had an elevated blood sugar there were parameters on the MARs. Staff needed to call a nurse immediately. Depending on how high the blood sugar was the nurse would proceed on an individual basis, there was no standard. Parameters were nursing guidelines and were not a physician's order.

Review of tenant files, review of MARs and staff interviews were conducted. The monitor was not able to determine a preponderance of evidence to substantiate the allegation.

- Regulatory Insufficiency: None noted.

B. Medications

Complaint/Incident Allegation: It was alleged an insulin prescription box labeled with a tenant's name was found with another tenant's insulin pens.

- Monitoring Observation: An audit of insulin pens was conducted by the monitor.

  There were three tenants (Tenants #1, #2 and #4) who had the Program administer insulin via insulin pens. Tenant #1 received Lantus and Novolog insulin. All boxes and pens were labeled with Tenant #1's name. Tenant #2 received Novolog and Lantus insulin. All Novolog pens were labeled with Tenant #2's name, except for one insulin pen. One Lantus pen did not have a label with Tenant #2's name. Tenant #4 received Lantus insulin and all pens were labeled with Tenant #4's name.

  Staff #1, #2 and #3 stated they had never used one tenant's medication to give to another tenant and they were not aware of any other staff using one tenant's medications for another tenant. The Nurse stated staff did not use one tenant's medications for another tenant, not even Tylenol. The ED stated "absolutely not" when asked if staff used one tenant's medications for another tenant. She stated that would not be okay. She had personally gone to the pharmacy to pick up medications, even if it was Tylenol.

  The Nurse stated the pharmacies delivered medications between 4:30 p.m. and 5:00 p.m. every day. Two different pharmacies were used. On the weekends the deliveries were at 12:00 p.m. or at 4:00 p.m. If an order was received for an immediate need, someone (from the pharmacy) delivered it. The Nurse stated empty insulin pen prescription boxes were shredded.

The ED stated she had a bin in her office to collect shredding. Shredding was then taken from her office, down the hall, through a service door into a locked storage room where a large locked shredding bin was located. A key was always needed to enter the storage room. The collection container was a large container with a small narrow opening in which to drop in the shredding. The monitor observed the process and saw the locked container. The ED stated she had no idea how one tenant's prescription box could be left in another tenant's room, although all staff were human and errors could happen. If something was left in the wrong tenant's room, if it was a medication, it would be discovered during the six rights of medication administration.

A review of tenant insulin pens used for administration by the Program, staff interviews and the collection process for shredding was completed. The monitor was not able to determine a preponderance of evidence to substantiate the allegation.

- Regulatory Insufficiency: None noted.