IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 45090-I

October 21, 2013

Ms. Gayla Gilliland, Administrator
Windsor Manor Assisted Living
608 South 15th Street
Indianola, IA 50125

RE: Final Complaint/Incident Investigation Report – Windsor Manor Assisted Living, Indianola, IA

Dear Ms. Gilliland:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of October 2 & 14, 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: **Complaint/Incident Intake #:** 45090-I

Gayla Gilliland, Administrator
Windsor Manor Assisted Living
608 South 15th Street
Indianola, IA 50125

Date of Complaint/Incident Investigation:

October 2 & 14, 2013

Monitor(s):

Hal L. Chase, RN BSN MPH

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:	24
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	28

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	8
TOTAL census of Assisted Living Program	36

Program History – The Program received a regulatory insufficiency in the area of Structural during the Sept. 2012 Recertification on-site.

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

A. Dependent Adult Abuse

Complaint/Incident Allegation: The Program reported staff notified the registered nurse (RN) on 8-15-13, a tenant reported he/she was missing a wedding band and a mother's ring. The Administrator called family and asked if they had taken the rings home for safe keeping. Family reported they hadn't. A meeting was scheduled for 8-16-13 with the tenant and family. During this meeting, family reported the tenant was missing $212.00 in cash and 24 boxes of facial tissue. A thorough search of the tenant's apartment was completed and the rings, money and facial tissue were not found. During the search, the RN found several bottles of medications. The tenant had been self medicating until 7-12-13 when the Program began to administer medications. A prescription bottle of Xanax 0.25mg, quantity - 87 tablets filled on 7-3-13 was empty.

- Monitoring Observation: Tenant #1, a 90 year old, was admitted on 6-30-13 and had diagnoses of: Hypertension, Arthritis, Cellulitis, Anxiety Disorder, Byslipidemia, Edema, Esophageal Reflux, Hearing Loss, Limb Pain, Sensopineural Hearing Loss, Tinnitus and Vitamin B Deficiency. A Global Deterioration Scale (GDS), completed on 7-30-13, staged Tenant #1 at three, which indicated mild cognitive decline. Tenant #1 resided in the general population.

  Functional, cognitive and health evaluations were completed on 6-27-13 and indicated Tenant #1 needed assistance with activities of daily living ADLs), including assistance with ambulation, bathing and toileting and was independent with medications. Nurse's notes of 7-12-13 indicated Tenant #1 and Tenant #1's family requested staff to assist Tenant #1 twice weekly with showers and for the Program to

administer medications. The service plan of 6-27-13 was updated to reflect both changes.

Medication Administration Records (MARs) for July 12, 2013 indicated the Program began administering medications, including Xanax-0.25mg at night. A review of narcotic control counts beginning 7-12-13 through 8-31-13 indicated Xanax-0.25mg had been documented appropriately.

Evaluations and service plan of 7-30-13 indicated no changes in health status or changes in services. Nurse's notes of 8-15-13 at 7:00 p.m. indicated staff notified the RN, Tenant #1 had reported he/she was missing a wedding band and a "mother's ring." Nurse's notes of 8-16-13 indicated the Administrator initiated an investigation by meeting with Tenant #1 to try and develop a time line of the events, but Tenant #1 was "unclear" regarding when items were missing.

A search of Tenant #1's apartment was completed on 8-16-13. Nurse's notes did not indicate the rings were found but several bottles of medications had been "tucked into a chair side table." An empty bottle of Xanax, which had been filled on 7-3-13 with a quantity of 87 tablets were dispensed on 7-3-13. Pharmacy records revealed Xanax 0.25mg, had been prescribed on 3-27-13 with three refills made on 3-28-13, 7-2-13 and 7-3-13. The refill on 7-3-13 was for 87 tablets of Xanax-0.25mg.

On 8-16-13 the Program notified police and filed a police report of the missing items. The Department of Human Services and Aging Advocates were also contacted. On the same date but separate entry, the Administrator contacted Tenant #1's family to see if family had taken the rings home for safe keeping. Family reported they had not. The Administrator scheduled a meeting with Tenant #1's family for later that afternoon.

Nurse's notes of 8-16-13 indicated a meeting was held with Tenant #1 and Tenant #1's family. Family reported $212.00 in cash and 24 boxes of facial tissue were missing. Tenant #1's family member was interviewed on 10-15-13 by phone and reported Tenant #1's cousin had cashed a check for Tenant #1 and gave Tenant #1 $135.00 in cash (date unknown). Tenant #1's family member reported Tenant #1 had reported the $135.00 was missing (date unknown) and Tenant #1's family member gave Tenant #1 $50.00 in cash (date unknown). Tenant #1 reported the $50.00 given to him/her was missing and Tenant #1's family member gave Tenant #1 $20.00 for a beauty shop hair appointment (date unknown). Tenant #1's family member reported the amount missing or unaccounted for was $205.00. Tenant #1's family member reported he/she had not told the Program about the missing money until the Program notified him/her of Tenant #1's missing wedding ring and mother's ring.

The police report of 8-16-13 was updated on 8-26-13 and indicated the Program had hired a private investigation firm to conduct an investigation regarding the thefts.

The private investigative summary of 8-30-13 indicated the investigation failed to conclusively identify the person(s) responsible for the alleged thefts. On 9-4-13 the police report was updated and indicated Tenant #1's family had not returned phone calls to the police regarding the missing items. The police report indicated the investigation was inactive.

Nurse's notes of 8-19-13 indicated Tenant #1 used one to one and half boxes of facial tissue daily and considered the allegation of missing facial tissue to be incorrect. Tenant #1's family member reported she knew Tenant #1 had used large amounts of facial tissue and didn't believe boxes of facial tissue had been stolen.

The Administrator reported random drug screen tests were completed on at least 10 direct and indirect care staff on 8-12-13 who had access to Tenant #1's apartment and medications during the time the medication was reported missing. Drug tests for all staff tested were negative.

Program staff schedules for the periods listed above indicated at least 14 direct and indirect care staff had access to Tenant #1's apartment. The Program's internal investigation, police investigation(s) and subsequent Department's investigation concluded an alleged perpetrator was not identified.

Complaint/Incident Allegation: The Program reported a tenant had reported on 8-15-13 a bottle of Oxycodone, quantity 90 tablets he/she had picked up from the pharmacy on 8-8-13, "seemed to have fewer pills than before." On 8-19-13 a tenant reported a prescription of Ambien, quantity 30 tablets had been dispensed and picked up by the tenant on 8-8-13, had only seven tablets remaining. The tenant reported he/she had taken six tablets and 24 tablets should be left.

- Monitoring Observation: Tenant #2, a 65 year old, was admitted on 7-9-13 and had diagnoses of: History of Colon Cancer, Prostate Cancer, Spinal Stenosis, Thrombocytopenia, History of Benign Prostatic Hypertrophy, History of Urinary Tract Infections, Urinary Frequency, Urgency Incontinence, History of Falls, Alcohol Induced Dementia, Cirrhosis, Chronic Obstructive Pulmonary Disease, Chronic Pain, Peripheral Vascular Disease, History of Pneumonia, Colitis, Anemia, Tremors, History of Congestion, Depression, Anxiety, Agitation, Hypokalemia, Constipation and Diarrhea. A cognitive evaluation of 8-8-13 indicated normal cognition.

  Functional, cognitive and health evaluations were completed on 7-9-13 and 8-8-13 and service plans of the same dates indicated Tenant #2 was independent with all ADLs and administered his/her own medications independently.

  An incident report of 8-15-13 indicated Tenant #2 notified the Administrator and RN of missing Oxycodone – 90 tablets from a prescription bottle he/she had picked up at the pharmacy on 8-8-13. (Pharmacy records indicated Oxycodone 5mg – 90 tablets was dispensed and picked up by the tenant on 7-9-13 and not 8-8-13 as reported by the tenant.)

  Nurse's notes of 8-16-13 indicated Tenant #2 reported 49 tablets of Oxycodone was unaccounted for. Tenant #2 reported keeping medications on the counter in the kitchen area. According to Tenant #2, he/she picked up a prescription of Oxycodone 5mg – 90 tablets on 8-8-13.

  Tenant #2 reported he/she went out of town the afternoon of 8-8-13 and didn't return to the Program until 8-11-13. On 8-12-13, Tenant #2 attended the state fair and was out of the building from 8:30 a.m. to at 3:00 p.m. and went to take one of his/her pills

and noted the pill bottle "felt lighter" and the bottle appeared to have fewer pills than before.

Nurse's notes of the same entry (8-16-13) indicated the current count of Oxycodone 5mg was 34 tablets. Tenant #2 reported he/she had not taken that many. The Program notified the police and filed a police report. A police report of 8-15-13 indicated Tenant #2 was missing 40 tablets of Oxycodone. Tenant #2 reported the theft occurred sometime between 8-7-13 and 8-14-13. The police investigation indicated the report was forwarded to detectives for further investigation.

An incident report and nurse's notes of 8-19-13 indicated Tenant #2 reported his/her Ambien medication had filled on 8-8-13, with 30 tablets dispensed. Pharmacy records indicated Zolpidem Tartrate (Ambien) 10mg, quantity 30 tablets was dispensed and picked up by the tenant on 8-8-13.

Tenant #2 reported he/she had taken approximately six tablets, which should have left 24 tablets remaining, but only seven tablets were left. The Program notified the police and filed a police report. A police report of 8-19-13 indicated the Administrator believed a staff worker (not identified) had stolen approximately 17 Ambien tablets sometime between 8-16-13 and 8-19-13. The police report indicated there were no suspects at the present time.

The Administrator reported random drug screen tests were completed on at least 10 direct and indirect care staff on 8-12-13 who had access to Tenant #2's apartment and medications during the time the medication was reported missing. Drug tests for all staff tested were negative.

The Program hired a private investigative firm to conduct an investigation related to the thefts. The investigative summary of 8-30-13 indicated the investigation failed to conclusively identify the person(s) responsible for the alleged thefts.

Nurse's notes of 8-30-13 indicated Tenant #2 was discharged.

Program staff schedules for the periods listed above indicated at least 14 direct and indirect care staff had access to Tenant #2's apartment. Tenant #2 was independent with the administration of medications. There was no accurate accounting of the number of tablets taken by Tenant #2 during period in question. The Program's internal investigation, police investigation(s) and subsequent Department's investigation concluded an alleged perpetrator was not identified.

- Regulatory Insufficiency: None noted.