IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
45807-I

December 5, 2013

Ms. Denise Elsner, Coordinator
Courtyard Terrace Assisted Living
717 West 3rd Street
Boone, IA 50036

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

Dear Ms. Elsner:

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:

Denise Elsner, Coordinator
Courtyard Terrace Assisted Living
717 West 3rd Street
Boone, IA 50036

Complaint/Incident Intake #: 45807-I

Date of Complaint/Incident Investigation:

November 12, 2013

Monitor(s):

Lori Miner, RN BSN

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:	35
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	35
TOTAL census of Assisted Living Program	35

Program History – During the course of this certification period investigation the following regulatory insufficiencies in the areas of Medications, Staffing and Transportation were found,

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

A. Policies and Procedures

Complaint/Incident Allegation: The program reported a narcotic count was off and ten tablets of Hydrocodone were missing.

- Monitoring Observation: On 9-27-13, a narcotic count was completed for the Hydrocodone prescribed to Tenant #1. There were 22 pills present. On 9-28-13, the narcotic count was off by 10 pills. At the time, the program was counting narcotics once a day. In an interview with the Clinical Services Coordinator, Tenant #1 was the only tenant who had narcotics that were counted. The Clinical Services Coordinator stated there had been no other incidents of missing narcotics after 9-28-13.

  Tenant #1, an 83 year-old, was admitted on 10-6-12 and had diagnoses of: Hypertension, Arthritis, Depression, Dependent Edema, Degenerative Joint Disease, and Age Related Cognitive Decline. The cognitive screening tool did not indicate cognitive decline. The service plan of 7-31-13, and current at the time of the incident, indicated the program set up and administered medications to Tenant #1.

  An interview was conducted with Tenant #1. Tenant #1 confirmed the apartment was not always locked when leaving but staying within the building.

  A review of the Medication Administration Record for August 2013 indicated the program filled a medication planner weekly. Hydrocodone was added to the planner on 8-1 and 8-8-13.

The narcotic record sheet had an entry dated 8- 8-13 which indicated seven Hydrocodone were taken from the pill bottle and placed in the medication planner. The count after the pills were placed in the planner was 28.

In a physician's note dated 8-8-13, the physician stated Tenant #1 did not need to take Hydrocodone on a regular basis any longer. The order for the Hydrocodone was changed from daily at bedtime to every four hours as needed. The narcotic record sheet dated 8-9-13 indicated the count was 34. There was no written explanation for the increase in the count, but it did coincide with the removal of the Hydrocodone from the planner when the order went from daily to as needed.

During the months of August and September 2013, the narcotic record sheet documented the program was counting narcotics on a daily basis at 2:00 p.m. The exceptions were 8-18 and 9-6-13 when there was no documentation of a narcotics count.

On 9-27-13 the narcotics count was 22 pills. On 9-28-13, the narcotics count was 11. The PRN flow-sheet documented Tenant #1 received a dose of Hydrocodone on 9-27-13 at 10:20 p.m. after the 9-27 count and before the 9-28-13 count. When taking that into consideration, there were 10 pills missing. At the time, the program was not documenting pills removed from the bottle on the narcotics record.

On 9-28-13, a Saturday, at approximately 2:00 p.m., Staff #1 and #2 went to Tenant #1's apartment. At that time, the Hydrocodone was stored in a locked drawer in Tenant #1's bathroom. Written statements provided by the program to the department documented Staff #1 and #2 went to the apartment and counted the pills. The count was 11. Staff #1 and #2 forgot to take the count book with them, so they went back downstairs to the book. It was then noted the count was off by 10. Staff #1 and #2 went back up to Tenant #1's apartment and re-counted the pills. Again the count was off by 10. Staff #2 then called the program Registered Nurse (RN). The RN reported the incident to her superiors. A decision was made to complete an investigation on Monday, 9-30-13.

On 9-30-13, the Clinical Services Coordinator who was not at the program on 9-28-13, completed an incident report and statements were obtained from staff members working on 9-28-13. The local police department was notified and the program began the process of notifying the department.

A review of the staff schedule for 9-27 and 9-28-13 indicated Staff #4 and #5 worked 2-10 p.m. on 9-27, Staff #6 worked from 10 p.m. on 9-27 to 6 a.m. on 9-28, Staff #1, #3, and #7 worked hours between 6 a.m. and 2 p.m. on 9-28-13.

All of the staff identified as working on 9-27 and 9-28-13, were interviewed by the police department as well as another staff member #8, who "floated" to the assisted living program from another on-campus location to assist with lunch on 9-27-13. No perpetrator was identified and the police department closed the investigation pending any new information.

Staff #4 and #5 were both interviewed and stated they worked the 2 p.m. to 10 p.m. shift on 9-27-13. Staff #4 stated she counted with Staff #3 at 2 p.m. and the count was correct at that time. Each stated they did not see Staff #8 during their shift. Each stated Tenant #1 did not come down for the evening meal on 9-27-13, but spent the evening going back and forth between the laundry room and the apartment. Each stated they had a set of keys during the evening of 9-27-13. Each stated Tenant #1 did not lock the apartment door, and that the door to the staff office may not have been locked during the evening of 9-27-13. Staff #5 reported Tenant #1 wanted a pain pill before going to bed, which would have been after Staff #5's shift, so Staff #5 passed the information on to the night shift. Staff #4 also stated both sets of keys from the evening shift were given to the one night shift staff. It was reported the staff office door is now locked.

According to the "as needed" medication flow sheet, Tenant #1 received Hydrocodone on 9-27-13 at 10:20 p.m.

Staff #3 and #7, were interviewed. Staff #3 worked the day shift on 9-27-13, and worked from 6 a.m. to 10 a.m. on 9-28-13. Staff #3 stated she had her own set of keys to the medication drawers because she filled medication planners weekly. There were two additional sets per shift for each staff member working. When not needed additional sets of the medication keys were kept in the staff office. If Staff #3 was working with only one other staff person, as was the case on the morning of 9-28-12, the extra set of keys would have been kept in the staff office. The staff office door was not always locked, but reported to be locked after 9-28-13.

Staff #7 stated she worked 10 a.m. to 2 p.m. on 9-28-13 because someone had called in sick. Staff #7 did not count narcotics when she began her shift. Staff #7 stated Staff #3 had her own set of keys and there were two additional sets for staff member use. Staff #7 stated the additional keys were kept in the staff office which was locked. Staff #7 stated Staff #8 was at the program on 9-27-13 for lunch, but Staff #8 is no longer employed on campus.

On 9-28-13, a Saturday, at approximately 2:00 p.m., Staff #1 and #2 went to Tenant #1's apartment. At that time, the Hydrocodone was stored in a locked drawer in Tenant #1's bathroom. Written statements provided by the program to the department documented Staff #1 and #2 went to the apartment and counted the pills. The count was 11. Staff #1 and #2 forgot to take the count book with them, so they went back downstairs to the book. It was then noted the count was off by 10. Staff #1 and #2 went back up to Tenant #1's apartment and re-counted the pills. Again the count was off by 10. Staff #2 then called the program Registered Nurse (RN).

The RN was interviewed. She stated there had been no missing medications since 9-28-13. The RN stated she had been at the program since June 2013, and had instituted changes since the recertification visit. The RN stated Staff #8 was no longer employed on campus. The RN also confirmed the availability of keys on 9-27 and 9-28-13.

None of the staff interviewed identified a perpetrator.

The Clinical Services Coordinator was interviewed and stated Tenant #1 was the only tenant receiving narcotics in September. She also confirmed the availability of keys at the time of the incident. The Clinical Services Coordinator stated since the incident procedures have changed. There is now only one person with keys per shift. The keys are exchanged during the narcotic count which is completed with each shift change. Narcotics are no longer kept in tenant apartments, but in a secure double-locked location. There have been no further instances of missing narcotics.

During the onsite visit, Tenant #1's Hydrocodone was counted and observed to be correct with the narcotic record sheet.

The narcotic record sheet was reviewed. The July 2013 count was off by two on 7-25-13; two pills were missing. At that time, the program was counting the pills weekly. At the end of July 2013, the program switched from counting the pills weekly to counting the pills daily. The daily pill count was not completed on 8-18 and 9-6-13. The procedure established by the program, daily pill counts, was not completed.

The Medication Administration Records (MAR), "as needed" (PRN) medication sheets and narcotics records were compared for July and August 2013. The PRN medication sheet indicated Hydrocodone was given to Tenant #1 on 8-15, 8-16, and 8-17-13. There was no documentation of the effectiveness of the medication. A review of MAR revealed no documentation of the administration of Hydrocodone on 8-15 and 8-16-13.

The MAR, the PRN sheet, and the narcotics record were compared for September 2013. There was no documentation of effectiveness of the Hydrocodone on three occasions. Hydrocodone was documented as given on the PRN sheet on 9-18-13 but not on the MAR. On 9-24-13, Hydrocodone was documented on the MAR as given, but was not documented on the PRN Sheet.

According to the medication policy dated 8- 9-13, PRN medication was to be charted on the MAR and PRN sheet and was to include a response to the medication. The program did not follow its medication policy.

In summary, the incident report of the 9-28-13 incident was not completed by an onsite staff member. The incident report and investigation was not completed until two days after the incident.

The established pattern of daily narcotics counts was not completed on two occasions. The medication policy stated the MAR and PRN sheet would both contain documentation of medications administered as needed, which was not completed on two occasions. Effectiveness of the medication was not documented on at least three occasions.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)

- Regulatory Insufficiency: The person in charge at the time of the incident shall prepare and sign the report. (IAC r. 481-67.2(1)(c))