IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 47089-I

October 3, 2014

Ms. Elaine Helgeson, Administrator
Mills Harbour Independent and Assisted Living
311 South 10th Avenue East
Lake Mills, IA 50450

RE: Final Complaint/Incident Investigation Report – Mills Harbour Independent and Assisted Living, Lake Mills, IA

Dear Ms. Helgeson:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of April 9, 10, September 25 and 29, 2014, 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 #:** 47089-I

Elaine Helgeson, Administrator
Mills Harbour Independent/Assisted Living
311 South 10th Avenue East
Lake Mills, IA 50450

Date of Complaint/Incident Investigation:

April 9, 10 and September 25 and 29, 2014

Monitor(s):

Stephanie Cummins, MA

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:	0
Total Population of Program at time of on-site	22
TOTAL census of Assisted Living Program	22

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

A. Medications

Complaint/Incident Allegation: The Program reported three tenants were missing medications.

- Monitoring Observation: Tenants #1, #2 and #3 had missing medications.

  Tenant #1, a 96 year old, was admitted on 12-1-11 and diagnoses included: Chronic Pain and Anxiety. The service plan indicated Tenant #1 received assistance with medication administration. According to a Medication Review Report, Tenant #1 had an order for Lortab (Hydrocodone/Acetaminophen) 5/500 milligram (mg) give one tablet by mouth three times per day. The order date was indicated as 12-4-13. The order was changed on 2-4-14 and reflected Hydrocodone/Acetaminophen 5/325 mg take one tablet by mouth three times a day for pain.

  Tenant #2, a 75 year old, was admitted on 7-29-13 and diagnoses included: Major Depressive Disorder, Hypertension (HTN), Chronic Pain, Esophageal Reflux, Constipation, Urinary Incontinence and Hypothyroidism. The service plan indicated Tenant #2 received assistance with medication set up. According to a Medication Review Report, Tenant #2 had an order for Norco (Hydrocodone/Acetaminophen) 5/325 mg give one tablet as needed for pain three times daily (supervised self-administration) set up three tablets per day for a total of 21 tablets each week. The order date was indicated as 8-29-13.

  Tenant #3, an 86 year old, was admitted on 9-1-13 and diagnoses included: Rheumatoid Arthritis, Calcifying Tendinitis of Shoulder, HTN, Atrial Fibrillation, Osteoporosis and Chronic Pulmonary Heart Disease. The service plan indicated Tenant #3 did not receive assistance with medication administration. According to a Program document, Tenant #3 had a script for Hydrocodone/Acetaminophen.

According to a Program document, a suspected theft of medications was discovered on 2-3-14. Staff noticed the numbers and appearance of medications was not matching up with other medications in a medication bottle for a tenant. The dispensing pharmacy was contacted and the tablet in the bottle was identified as over the counter (OTC) generic extra strength Tylenol. An inventory of the medications in question was completed. Tenant #1 had 88 tablets remaining and 8 were the actual 5/500 mg Lortab and the remaining 80 tablets were a combination of 3 different OTC generic extra strength Tylenol. Tenant #2 had 18 tablets in an existing bottle and all were found to be OTC generic extra strength Tylenol. In Tenant #2's new script received on 1-29-14, 45 of the 60 Norco 5/325 mg tablets were a form of generic extra strength Tylenol and 15 tablets were the actual Norco script. The Program replaced the medications at no cost to the tenants. Tenant #1 and Tenant #2 were informed of the incident and both reported no significant change in pain levels. The Program implemented immediate corrective protocol including any medications maintained in the Program's locked narcotic box would be taken at the end of the evening shift (daily) to the charge nurse at the nurse facility.

According to a Program document, on 5-20-14 Tenant #3 reported Tenant #3 had medications missing. Tenant #3 had 57 unaccounted for tablets of Hydrocodone/Acetaminophen. The Program's corrective action included having maintenance install locks in each apartment and the master keys would be maintained and locked in the business office with the Administrator. Tenant #3's medications were replaced by the Program.

Through the course of the investigation it could not be determined what happened to the missing medications for Tenants #1, #2 and #3. The Program completed an investigation of missing medications, notified local law enforcement and contacted the Department. In an interview on 9-25-14 the Administrator said there had been no additional reports of missing medications.

Per interviews, review of tenant files and review of Program records it could not be determined what occurred regarding the missing medications.

- Regulatory Insufficiency: None noted.