IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 49673-I, 49683-I

October 8, 2014

Ms. Deanna Fisher, Administrator
Cedars of Madrid Homes
600 North Kennedy Avenue
Madrid, IA 50156

RE: Final Complaint/Incident Investigation Report – Cedars of Madrid Homes, Madrid, IA

Dear Ms. Fisher:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of September 25 and October 2, 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 #:** 49673-I & 49683-I

Deanne Fisher, Administrator
Cedars of Madrid Homes
600 North Kennedy Avenue
Madrid, IA 50156

Date of Complaint/Incident Investigation:

September 25 and October 2, 2014

Monitor(s):

Margaret Kaltefleiter, RN MS
Michael Rohner, OTR/L

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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	33
Number of tenants with cognitive disorder:	11
Total Population of Program at time of on-site	44
TOTAL census of Assisted Living Program	44

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

A. Medications

Complaint/Incident Allegation #49673: The Program reported Tenant #1 had missing medications.

- Monitoring Observation: Tenant #1, a 79 year old, was admitted on 5-25-11 and diagnoses included: Morbid Obesity, Depression, Bilateral Knee Osteoarthritis and Mild Chronic Kidney Disease. According to an Incident Report dated 8-22-14 at 1:00 p.m., Tenant #1 reported Hydrocodone was missing. Staff immediately called the RN Service Coordinator to come to Tenant #1's apartment. .

  Tenant #1 was interviewed and stated Tenant #1 managed and ordered own medications. The medications were delivered by mail to the Program. When the medication arrived at the Program they were signed for by the receptionist and placed in Tenant #1's mail box located near the Program's main entrance. With the use of a key, Tenant #1 removed the packaged medication from the locked mailbox and took to apartment. Tenant #1 removed the medication from the shipping package and placed the medication either in a drawer of the nightstand, in a pocket on the side of the recliner or on the kitchen table in the apartment. The medications were not counted on delivery and a count had not been maintained while in the tenants' possession. Tenant #1 reported Tenant #1 did not lock up the medication and confirmed the door to the apartment had not always been locked. Tenant #1 reported the bottle was a new bottle of Hydrocodone that hadn't yet been opened. Tenant #1 had placed the bottle of Hydrocodone on the kitchen table and thought it had been sitting out for at least a week. Tenant #1 reported several staff including maintenance; housekeeping, the Administrator, the RN Service Coordinator and Tenant #1's family had been in the apartment. The receipts that accompanied the bottle of Hydrocodone and the actual bottle itself had been discarded by Tenant #1.

The RN Service Coordinator was interviewed and stated on 8-18-14 a staff requested she talk with Tenant #1. Tenant #1 reported he/she retrieved a new bottle of Hydrocodone from the kitchen table and it wasn't full. The RN Service Coordinator and Tenant #1 counted the medication for a count of 29 pills. Tenant #1 reported Tenant #1 took one and one half to two pills at night. The bottle should have had 90 pills in it. Tenant #1 reported Tenant #1 did not know when the bottle was received. The actual length of time the bottle had been sitting out on the kitchen table could not be determined. The RN Service Coordinator reported per review of the label, the bottle had been filled on 8-12-14. The mail order medication took five to six days to deliver to the Program. It was assumed that the bottle was the most recent delivery but could not be confirmed as Tenant #1 handled own scripts and ordered own medication. The RN Service Coordinator searched Tenant #1's apartment for loose Hydrocodone or another possible bottle. One Hydrocodone pill was found in a bottle that had been discarded. All garbage cans, cupboards and drawers were checked. No other bottles were found. Counting the Hydrocodone was started immediately and continued for Tenant #1's Hydrocodone. There had been no other reports of missing medications. The RN Service Coordinator reported Tenant #1 had refused to lock up the medication prior to the incident on 8-22-14 and had continued to refuse to secure the medication. Tenant #1 had become very possessive of the Hydrocodone and when counts were questioned become defensive and reluctant to cooperate with the Program.

The Administrator was interviewed and stated for those tenants who self-administered medications, the Program's policy was hands off. The tenants made their own appointments and filled their own prescriptions. There was no record of inventory on the narcotics for those that self-administered their medication. There had been no other reports of missing medications.

An incident report was completed and the Department was notified.

Per review of Tenant #1's file, incident report and interviews with Tenant #1, the RN Service Coordinator and Administrator, there was a possibility a narcotic medication was missing but it was not possible to determine whether or not the medication was actually missed.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation #49683: The Program reported Tenant #2 had left the Program without staff knowledge.

- Monitoring Observation: Tenant #2, an 88 year old, was admitted on 8-2-14 and diagnoses included: Essential Hypertension, Dementia, Osteoporosis, Depression and Venous Stasis Lower Extremities. On 8-2-14 Tenant #2 was staged at a four on the Global Deterioration Scale which indicated moderate cognitive decline. According to an Incident Report dated 8-18-14 at 6:45 p.m., at about 6:15 p.m., shortly after dinner, Tenant #2 had asked if he/she could go out the front door and see Tenant #2's spouse. Tenant #2 thought the spouse was in a red car waiting for Tenant #2. A red car had

pulled out of the driveway and Tenant #2 thought it was the spouse. Staff redirected Tenant #2 back to Tenant #2's room, telling Tenant #2 they would let Tenant #2 know when it was the spouse. Tenant #2 went to the room. Maybe 15 minutes later Tenant #2 was back at the door looking for spouse. Staff got Tenant #2 back to Tenant #2's room and said they would call Tenant #2. There was a 7:00 p.m. meeting scheduled in the Program so many people were coming in and staff had to set the alarm many times. About 6:45 p.m. another tenant had gone outside and came back in telling staff Tenant #2 was outside. Staff #1 went out and talked to Tenant #2 to see where Tenant #2 was going. There was a red car parked in the spot and Tenant #2 thought it was Tenant #2's car. Staff #1 asked Tenant #2 to come in and Tenant #2 agreed. At 8:00 p.m. Staff #1 checked on Tenant #2 who was sitting in a chair in the bedroom watching the red car.

According to a Nurses Note dated 8-19-14, the RN Service Coordinator was informed of the incident and came in on 8-18-14 to apply a monitoring device. A urinalysis was completed to rule out a urinary tract infection and was negative.

Copies of Daily Checklist for Monitoring Devices were provided with a device activation date of 8-18-14 for Tenant #2. The device was activated on 8-18-14 and was consistently checked each shift from 8-19-14 through 8-25 14. Starting on 8-26-14, the device was checked one time per day. Documentation of daily checks was provided from 8-26-14 through 10-2-14.

The RN Service Coordinator was interviewed and stated staff called her and said another tenant came into the building from outside and stated Tenant #2 was out there. Staff went out and easily redirected Tenant #2 back into the building. There were lots of people coming and going in and out of the Program for about 30 minutes for a meeting and the alarm kept going off and needed to be reset. Staff never saw Tenant #2 exit the building. The RN Service Coordinator came to the Program and placed a monitoring device on Tenant #2 who was agreeable to wearing it. The RN Service Coordinator stated Tenant #2 did not have any wandering or exit behaviors prior to or since the incident.

The Administrator was interviewed and stated she received a call one evening stating Tenant #2 walked out of the building and the RN Service Coordinator was going to place a monitoring device. The evening of the incident there was a community event in the building. Tenant #2 thought Tenant #2's family was coming and Tenant #2 kept looking out the door for them. The Program had a video camera on the door that showed Tenant #2 visiting with others coming in the building and recorded staff bringing Tenant #2 back into the building. There was no recording of Tenant #2 leaving the building. Based on the recording times, Tenant #2 was out of the building for less than 15 minutes. The Administrator stated Tenant #2 did not have any wandering or exit seeking behaviors before or after the incident. She talked with staff to make sure they stayed at the doors and watched the monitors because there was a short time delay before the doors reset.

A floor plan of the building and grounds was provided that reflected the location of Tenant #2's apartment and the potential route taken to where Tenant #2 was found outside. The monitor walked from the front door to the parking space where Tenant #2 was found (approximately 177 feet) taking sidewalk the entire way.

The monitor reviewed the times the front door alarmed and was reset between 6:00 p.m. and 7:00 p.m. on 8-18-14. There was a total of seven times the doors alarmed and were reset. The doors were reset within 6 seconds to 31 seconds after alarming.

According to the State Climatologist, on 8-18-14 at 6:35 p.m. at the Boone airport it was 82 degrees, winds from the southwest at 6 miles per hour with gusts up to 17 miles per hour, clear skies and a heat index of 86 degrees.

An incident report was completed and the Department was notified.

Per review of Tenant #2's file, incident report, interviews with the RN Service Coordinator and Administrator indicated Tenant #2 had left the building without staff knowledge and was easily redirected inside without any further wandering or exit seeking.

- Regulatory Insufficiency: None noted.