IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
55993-I

November 10, 2015

Mr. Ted Gorter, Manager
Parker Place Retirement Community
707 Highway 57
Parkersburg, IA 50665

RE: Final Recertification Evaluation & Complaint/Incident Investigation Report, Parker Place Retirement Community, Parkersburg, Iowa

Dear Mr. Gorter:

Enclosed is the **Final Recertification Evaluation & 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, following an investigation by DIA on **October 29 & November 2, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Program policies and procedures and Staffing.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

If you have any questions in regard to 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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0300	A. BUILDING: _____ B. WING _____	C 11/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER PLACE RETIREMENT	707 HWY 57 PARKERSBURG, IA 50665

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 16 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 18 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 10 Total Population of Program at time of on-site: 11 TOTAL census of Assisted Living Program: 29 A recertification visit and investigation of Incident #55993-I was completed. There were regulatory insufficiencies related to the recertification visit and Incident #55993-I.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports 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.	A 003		

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A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of tenant files and review of Program documents the Program failed to follow the policy and procedure established by the Program for two of five tenant files reviewed (Tenants #1 and #4). Two tenants had behavior that required the completion of incident reports per the Program's policy regarding incident reports and the incident reports were not completed. (Recertification) 1. Tenant #1, a 49 year old, was admitted on 4-26-14 and diagnoses included: Parkinson's disease, dementia, depression, hypertension (HTN), bipolar disorder, impulsive control disorder, history of aggressive behavior, history of auditory and visual hallucinations and vitamin B12 deficiency. Tenant #1 was staged at a three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline. According to Nurse's Notes dated 9-7-15, on 9-4-15 at 4.10 p.m. staff reported Tenant #1 had a sexual behavior in a public place of the Program. According to a Staff Documentation/Communication to RN document, on 9-4-15 at 4:10 p.m. Tenant #1 had a sexual behavior in a public place of the Program. The document indicated it was the second time that week. According to Nurse's Notes dated 9-23-15, an incident report was received from 9-22-15 at 8:15 p.m. and 8:40 p m., both regarding the same incident where Tenant #1 had a sexual behavior in a public place of the Program. Incident reports were completed regarding the incidents on	A 003		

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A 003	Continued From page 2 9-22-15 at 8:15 p.m. and 8:40 p.m. An incident report was not completed for the incident on 9-4-15. An incident report was not completed as needed. 2. Tenant #4, a 75 year old, was admitted on 6-30-11 and diagnoses included: HTN, diabetes mellitus, dementia (Alzheimer's type), history of alcohol abuse and tobacco addition, chronic obstructive pulmonary disease, depression, anxiety, vitamin B12 deficiency, orthostatic hypotension, muscle weakness and tinnitus. Tenant #4 was staged at a two on the GDS, which indicated very mild cognitive decline. According to Nurse's Notes dated 6-9-15, on 6-6-15 at 3:10 p.m. Tenant #4 came up behind staff to ask staff for the code to the southeast door as staff was resetting it. Staff told Tenant #4 staff was unable to give Tenant #4 the code. Tenant #4 then touched staff inappropriately and laughed. According to Nurse's Notes dated 10-8-15, Tenant #4 stuck Tenant #4's tongue out and made an inappropriate comment to staff. It was discussed with Tenant #4 and Tenant #4 apologized. According to a Staff Documentation/Communication to RN document, on 10-4-15 at 4:45 p.m , for the past few days Tenant #4 stuck Tenant #4's tongue out at staff and wagged it at staff. On 10-4-15 Tenant #4 made an inappropriate comment to staff. Incident reports for the last six months for Tenant #4 were requested and there were no incident reports provided for the incident on 6-6-15 or on	A 003		

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A 003	Continued From page 3 10-4-15. Incident reports were not completed as needed. The Program had reported a similar incident regarding Tenant #4 on 5-22-14. 3. According to the Program's policy regarding incident reports, each employee would immediately notify the Nurse/Manager if a tenant became ill, had fallen, their behavior was abnormal or any unusual event occurred. An incident report form would be completed by the Health Care Coordinator or Manager for documentation purposes. The Manager or Health Care Coordinator would indicate a person in charge on the schedule to fill out the report in their absence.	A 003		
A 063	481-67.9(4)f Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided This REQUIREMENT is not met as evidenced by: Based on review of tenant files, staff interviews, observation and review of Program documents the Program failed to have staff provide services in accordance with the training provided regarding narcotic counts and the administration of medications for two tenants (Tenants #2 and #6). (Recertification and Incident #55993-I)	A 063		

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A 063	Continued From page 4 1. Tenant #2, a 92 year old, was admitted on 6-28-10 and diagnoses included: glaucoma, anemia, atrial fibrillation, chronic obstruction pulmonary disease, hyperkalemia, depression, hypertension (HTN), hyperthyroidism and lymphedema. Tenant #2 received Hospice services. Tenant #2 was staged at a three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline. According to a service plan dated 9-2-15, Tenant #2 was on Hospice and had medications for pain and anxiety. Staff was to administer medications as prescribed by the doctor and as the medication administration record (MAR) indicated. Due to decline and expected further decline in health Tenant #2 might wish to have medications crushed and put in a soft food or might use liquid medications. Staff was to alert the nurse if Tenant #2 had trouble taking whole pills. Medications were stored in a locked cupboard or drawer in Tenant #2's apartment. According to a Physician's Order Form, Morphine O/S 20 milligram (mg)/milliliters (ml) ETH 30 ml, give 5 to 10 mg every two hours as needed for pain was ordered. The order date was 7-15-15. Review of Tenant #2's MARs from July to October were reviewed. There was one dose of the medication administered from 7-15-15 to 10-27-15, which was documented as administered on 8-5-15. Medication Tracking Sheets for Tenant #2's Morphine 20 mg/ml from 7-15-15 to 10-27-15 were reviewed. On 7-15-15 the quantity dispensed was 30 ml. On 8-5-15 at 11:00 a.m. 0.25 ml was administered with 29.75 ml remaining. From 8-5-15 at 3:00 p m. to 10-27-15	A 063		

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A 063	Continued From page 5 at 7:05 a.m. the count was documented as counted with two staff, at least at every shift change and the amount remaining was 29.75 ml. According to a Medication Tracking Sheet for Tenant #2's Morphine 20 mg/ml, from 10-24-15 at 4:30 p.m. to 10-27-15 at 7:05 a.m. the medication was documented as counted 10 times with 6 different staff. Staff that documented the count of Tenant #2's Morphine included: Staff A, B, C, D, E and the Manager. According to an incident report dated 10-27-15 at 4:00 p.m., the Hospice nurse wanted to see Tenant #2's Morphine and then it was discovered it was missing. Prior to the discovery of the missing medication (on 10-24-15), a Hospice nurse requested to see the Morphine on hand for Tenant #2. Staff unlocked the drawer and the Hospice nurse got the Morphine and other medications out to explain how and when to administer. The medications were supposedly placed in the drawer and locked. From 10-24-15 to 10-27-15 staff did not administer the liquid Morphine and signed off the count without visually looking at it. Drug screens were conducted on all staff. Tenant #2's apartment was searched, staff was counseled about narcotic counting and interviews were conducted. Hospice, the police department and the Department were notified. A self-report was submitted to the Department. The medication was replaced by Hospice in case of need and was stored in the nurse's office. According to a Program document, six staff received verbal counseling regarding the missing narcotic and the signature of the narcotic count	A 063		

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A 063	Continued From page 6 without visualizing the liquid narcotic. Those staff included: Staff A, B, C, D, E and the Manager. Review of Program documents indicated Staff A, B, C, D, E and the Manager had documented training on counting narcotic medication. The delegation document indicated when giving a controlled substance the medication needed counted and documented at the end of each shift, two employees went into each apartment, the medication was taken out of the drawer and counted. Both parties visualized and counted the medications. The date, time, shift and number of medication were documented and both parties signed to verify the number of medications. One staff documented and one staff counted. According to a Program document, Staff C, D and E admitted staff signed for the count of Tenant #2's Morphine without visualizing the medication. According to an interview with Staff B, prior to the discovery of the missing medication she last saw Tenant #2's box of Morphine on 10-21-15 and could not recall the last time it was counted. The box was sealed and no one had used it. Staff B would ask the staff on duty before her if they administered it (Tenant #2's Morphine) during their shift. If staff said no, Staff B would take their word for it. Staff B said staff received re-education on narcotic counts. Staff B had not administered the Morphine to Tenant #2. According to an interview with the Manager, narcotics were counted with Staff A at approximately 4:30 p.m. and with Staff C at approximately 7:00 p.m. (on 10-24-15). Neither the box or bottle of Tenant #2's Morphine was observed by the Manager at the time of the counts.	A 063		

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A 063	Continued From page 7 According to an interview with the Nurse Clinician, on 10-27-15 the Hospice nurse asked about Tenant #2's Morphine and they realized the box and bottle were missing. Staff was supposed to be counting narcotics. Staff signed off they counted the Morphine without visualizing the medication. Statements from staff regarding why the medication was not visualized included: it was hard to measure and it was not given, which kept the count the same. Staff did not look at the box or bottle at the time of the counts. Staff had counted other as needed oral narcotic medications as required. 2. Tenant #6, a 90 year old, was admitted on 7-21-14 and diagnoses included: HTN, hard of hearing, dementia, hyperlipidemia,, hyperglycemia, hernia surgery and urinary incontinence at night. Tenant #6 was staged at a three on the GDS, which indicated mild cognitive decline. According to a November 2015 MAR, Tenant #6 had an order for Furosemide 20 mg, one tablet twice daily at 8.00 a.m. and 12:00 p.m. Tenant #6 also had an order for a nasal decongestant 30 mg, one tablet, three times daily at 8:00 a.m., 12:00 p.m. and 5:00 p.m. Staff A, had documented nurse delegated training on medication administration. A medication pass was observed on 11-2-15 with Staff A Staff A washed her hands in the fitness room prior to entering Tenant #6's apartment and used hand sanitizer in the apartment. Staff A put the Furosemide in a medication cup. Staff A attempted to put the nasal decongestant into the medication cup and the pill landed on the MAR	A 063		

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A 063	Continued From page 8 book. Staff A picked up the nasal decongestant pill with Staff A's bare hand and put the pill into the medication cup. Staff A took the medication cup to Tenant #6 and Tenant #6 consumed the medication. Staff A did not provide the administration of medications in accordance with the training provided. According to an interview with the Nurse Clinician, if a pill was dropped on the MAR book the expectation would be that staff pick up the pill with a gloved hand and put it in the cup.	A 063		

PARKER PLACE
RETIREMENT COMMUNITY

707 Highway 57, Parkersburg, Iowa 50665 • Phone: 319-346-9771• Fax 319-346-9975

Ted Gorter, Manager
Parker Place Retirement Community
707 Hwy 57
Parkersburg, Iowa 50665

Rose Boccella
Program Coordinator
Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

Dear Rose,

Enclosed is the Plan of Correction (POC) in response to the recertification, complaint/incident investigation #55993-I visit at Parker Place dated November 10, 2015, conducted by Stephanie Cummins on October 29 and November 2, 2015.

If you have any questions, please feel free to contact me at 319-346-9771, or email me at manager@parkerplaceretirement.com.

Sincerely,

Ted Gorter

Ted Gorter, Manager
Parker Place Retirement Community
707 Hwy 57
Parkersburg, Iowa 50665

Parker Place Retirement Community
707 Hwy 57
Parkersburg, Iowa 50665
Ph: 319-346-9771
Fx: 319-346-9975

Date: 11/11/15

Complaint/Investigation Intake #'s: 55993-I

Plan of Correction (POC) Submitted For:

- Recertification/Investigation Date: 10/29/15 and 11/2/15
- Monitor: Stephanie Cummins

POC:

A. Discrepancy: Program Policies and Procedures

a. **Regulatory Insufficiency:**. **481-67.2 (231A, 231B, 231C)** Program Policies and Procedures, including those for incident reports. 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.

Program POC:

1. **Elements detailing how the program will correct the insufficiency as it relates to the tenant:**

   The Program RN will conduct mandatory training with all Staff to review Policies and Procedures regarding incident reports during the staff in-service training on November 19.

   With respect to the tenants involved and all other tenants in the program when an incident occurs the employee(s) on duty will immediately notify the Program Nurse and/or Manager if a resident becomes ill, has fallen, changes in usual behaviors or any unusual event occurs and complete an incident report form.

2. **Actions program taking to protect tenants in similar situations:**

   The Program RN and Manager will review all Incident Reports during the community stand-up meeting and ensure that the incident report is completed correctly.

The Program RN will ensure that all nursing note documentation will have a corresponding incident report to correlate with the event.

3. **Measures taken to ensure problem does not recur:**

The Program RN will ensure staff comprehension and competency through review of incident reports that are reported and documented according to policies and procedures.

The Program RN and/or Manager will conduct routine and ongoing trainings to ensure compliance and understanding of policies and procedures during monthly in-services, annually, and as needed.

4. **Date by which the regulatory insufficiency will be corrected:**

The Regulatory insufficiency based on policies and procedures will be corrected and in place by November 30, 2015.

B. Discrepancy: Staffing

A. **Regulatory Insufficiency: 481-67.9(231B, 231C, 231D)** Staffing. 67.9(4)f Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided

Program POC:

1. **Elements detailing how the program will correct the insufficiency as it relates to the tenant:**

The Program RN provided immediate counseling to all staff involved regarding the procedure on counting narcotics during shift change on October 24, 2015.

The Program RN contacted Hospice on October 24, 2015 to replace the missing narcotic to ensure resident had the prescribed medications to provide comfort measures.

The Program RN retrained the staff member on proper glove usage and medication administration and handling procedures on November 2, 2015.

2. **Actions program is taking to protect tenants in similar situations:**

All staff who are medication managed will be retrained on narcotic counts and medication administration by the Program RN and new delegations will be signed off for each of those staff members.

The Program RN will conduct random checks of all narcotic medications in the program to ensure counts are accurate and medications are in place.

When the pharmacy sends refills, the Program RN or delegated staff completes the count and documentation during the "checking-in" of meds. Upon destruction, count is to be verified by RN and another staff member and documented with signatures, date, time and count, then destroyed.

3. **Measures taken to ensure problem does not recur:**

The Program RN will conduct routine unannounced inspections at least monthly.

The Program RN will hold an annual retraining session for re-delegating staff for medication management.

4. **Date by which the regulatory insufficiency will be corrected:**

The Regulatory insufficiency based on staffing will be corrected and in place by November 30, 2015.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.