IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 42128-I

January 24, 2013

Ms. Brenda Colvin, Executive Director
Vriendschap Village Assisted Living
2604 Fifield Road
Pella, IA 50219

RE: Final Complaint/Incident Investigation Report – Vriendschap Village Assisted Living, Pella, IA

Dear Ms. Colvin:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of January 16, 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 #:** 42128-I

Brenda Colvin, Executive Director
Vriendschap Village Assisted Living
2604 Fifield Road
Pella, IA 50219

Date of Complaint/Incident Investigation:

January 16, 2013

Monitor(s):

Margaret Kaltefleiter, RN MS

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:	29
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	32

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	4
TOTAL census of Assisted Living Program	36

Program History – The program did not receive any regulatory insufficiencies during this certification period.

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

A. Other

Complaint/Incident Allegation: The Program reported a tenant's family member called and was concerned a tenant sounded suicidal. Program staff found the tenant lying on the floor next to the bed and called 911. Staff noted a bottle of pills on the nightstand.

- Monitoring Observation: Three tenant files (Tenants #1, #2, and #3) were reviewed. Tenant #1 had attempted suicide.

  Tenant #1, a 75 year old was admitted on 12-26-12 and diagnoses included: Traumatic Brain Injury. Tenant #1 was staged at a three to four on the Global Deterioration Scale on 12-17-12 which indicated mild to moderate cognitive decline.

  According to Nursing Progress Notes dated 12-27-12 at 10:00 a.m., a lengthy discussion about medications was conducted with Tenant #1 and a family member. The family member believed that Tenant #1 needed several additional medications. The Program Nurse explained a doctor's order was needed for any medications the Program assisted with and the doctor would be contacted for clarification. Tenant #1 was leaving with a family member after lunch for an overnight holiday party. Medications were sent with Tenant #1. According to Nursing Progress Notes dated 12-31-12 at 9:00 a.m., Tenant #1 was in bed with complaint of a headache. According to Nursing Progress Notes dated 1-2-13 at 2:00 p.m., Tenant #1 had not gotten up that day. That morning Tenant #1 stated he/she had diarrhea. A family

member reported Tenant #1 found out this afternoon that a friend had died. Trays for both meals were delivered to the room. According to Nursing Progress Notes dated 1-3-13 at 3:30 p.m., Tenant #1 stayed in the apartment all day. A family member stated Tenant #1 had taken the death of a friend very hard. Tenant #1 was going to the funeral this weekend. Tenant #1 refused early morning medications several times. According to Nursing Progress Notes dated 1-4-13 at 10:10 a.m., Tenant #1 wanted medication times changed and this was done. Tenant #1 came to the dining room for breakfast and stated he/she would come to the dining room for lunch. Tenant #1 left with a family member before lunch and had not returned as of 3:10 p.m. According to the Nursing Progress Notes dated 1-7-13 at 8:00 a.m., a family member reported that Tenant #1 had gone to the emergency room (ER) on 1-4-13 because Tenant #1 wasn't feeling well. Although, the family member said everything checked out; Tenant #1 was still not feeling well so they were going back to the ER. The family member was unable to say exactly what was wrong. At 3:51 p.m. a call from staff reported Tenant #1 and a family member had returned from the ER and the family member stated nothing was found to be wrong.

According to a Resident Incident Report dated 1-8-13, Tenant #1's family member called at 6:20 a.m. and asked that Tenant #1 be checked since the family member had received a call about possibly committing suicide. A call was made to 911 after finding Tenant #1 slumped over on the floor by the bed. Tenant #1 was moving but would not speak.

According to Nursing Progress Notes (dated 1-8-13 at 7:45 a.m.), at 6:28 a.m. the Program Nurse received a call from Staff #1. Staff #1 stated she had received a call from Tenant #1's family member at 6:20 a.m. asking for someone to check on Tenant #1. According to Staff #1, the family member was worried since Tenant #1 sounded suicidal. Staffs #1 and #2 entered the apartment to find Tenant #1 lying on the bedroom floor next to the bed. Staff #1 and #2 attempted to have Tenant #1 sit up and Tenant #1 did not speak. A call was made to 911. The police department and ambulance staff arrived quickly and took over. Staff #1 noticed an open bottle of pills on the nightstand. The label read Morphine and was a prescription from April 2009 prescribed to Tenant #1's family member. Staff #1 reported it looked like tissue had been stuffed into the bottle with many pills in the bottle. According to Nursing Progress Notes dated 1-8-13 at 1:40 p.m., a phone call was received from the hospital discharge planner stating Tenant #1 had been admitted to acute care.

According to Nursing Progress Notes dated 1-10-13 at 8:00 a.m., last evening Tenant #1's family members were at the Program moving out Tenant #1's furniture. The family members told staff Tenant #1 was being transferred to a hospital out of town.

Staff #1 was interviewed. Staff #1 was a Care Assistant and worked the night shift. Staff #1 was working from 11:00 p.m. to 7:00 a.m. on 1-8-13 when a cook came in at 6:15 a.m. and said there was a call from Tenant #1's family member saying a message had been received from Tenant #1 that sounded suicidal. Staff #1 went to Tenant #1's room and found Tenant #1 sitting on the floor with back leaning towards the bed and slumped over to the right. Tenant #1's head was almost on the floor. Staff #1 tried to talk to Tenant #1 and tried to sit up Tenant #1. Tenant #1's eyes were open and Tenant #1 was breathing. Staff #1 found a bottle of pills on the nightstand that said Morphine. The bottle did not have a lid but two cotton balls and

toilet paper were in the bottle. Tenant #1's family member's name was on the bottle and it was a prescription from 2009. Staff #1 called a family member and called 911. The police arrived right away. The ambulance arrived and then a family member arrived. Staff #1 asked the family member where Tenant #1 could have gotten the medication and the family member responded that Tenant #1 had medications "stashed" all over in the apartment.

Staff #1 said she had only met Tenant #1 one other time when assisting with 6:30 a.m. medications. A family member was there at the time. Tenant #1 asked what the medications were for and it took about 10 minutes for Tenant #1 to take the medications.

Staff #2 was interviewed. Staff #2 said Staff #1 got her from another tenant's room. Staff #2 said Staff #1 told her Tenant #1's family member called at 6:20 a.m. and asked staff to check on Tenant #1. The family member received a phone call the night before and the Tenant sounded suicidal. Staff #1 tried to talk to Tenant #1 without any response. Staffs #1 and #2 tried to sit up Tenant #1 but Tenant #1 was limp but breathing. Staff #2 said there was a pill bottle on the nightstand that said Morphine and was in the name of Tenant #1's family member. The bottle was dated 2009 and said the quantity was for 100 pills but it looked like there were more than 100 pills in the bottle. Staff #1 called 911 before she got Staff #2. The police arrived and asked for help it getting Tenant #1 upright. Tenant #1 had one leg out in front and one in back, made noises, but did not answer questions. The ambulance arrived and Staff #2 left to go back to what she had been doing. Staff #2 said she had not previously met Tenant #1.

The Program Nurse was interviewed and provided a written statement. She indicated at 6:28 a.m. she received a phone call from Staff #1. Staff #1 had received a phone call from Tenant #1's family member at 6:20 a.m. asking staff to go check on Tenant #1. The family member stated the family member was kind of worried as Tenant #1 sounded suicidal. Staff #1 and #2 entered Tenant #1's apartment to find Tenant #1 lying on the bedroom floor next to the bed. Attempts were made to have Tenant #1 sit up and Tenant #1 would not speak. A call was made to 911. The police department arrived almost immediately and before the ambulance arrived a family member arrived. Staff #1 noticed an open bottle of pills on the nightstand. She read the label and it said Morphine and was a prescription dated April 2009 in the name of Tenant #1's family member. Staff #1 said it looked like tissue had been stuffed into the bottle and there appeared to be many pills in the bottle. Staff #1 later stated that the family member had received the phone call from Tenant #1 the night before around 10:00 p.m. but had not listened to the message until right before the family member called the Program. The Program Nurse stated by the time she arrived at the Program, Tenant #1 and the ambulance were already gone. The Program Nurse stated Tenant #1 gave no indications of depression. One of Tenant #1's family members was always at the Program and Tenant #1 was gone from the Program for three and one half days with the family member. Tenant #1 did not get up early and had asked for medications to be given later. The Program Nurse indicated on 1-8-13 at 1:40 p.m., a call was received from the hospital stating Tenant #1 was admitted to acute care. It was possible that Tenant #1 would be transferred to a psychiatric hospital the following day.

Review of Tenant #1's Resident Service Delivery Daily Record indicated Tenant #1 was gone from the Program from 2:00 p.m. on 12-27-12 through 9:30 p.m. on 12-29-12.

The ED and the Program Nurse stated the incident had been handled appropriately. An incident report was completed and the incident was reported to the Department.

Review of the Program's investigation, incident report, staff interviews and review of Tenant #1's file was completed. Prior to the time of the incident, Tenant #1 had not verbalized any suicidal ideations. Tenant #1 had been discharged from the Program.

- Regulatory Insufficiency: None noted.