IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

**Complaint/Incident Intake #:**
**43437-C**

May 30, 2013

Ms. Brenda Colvin, Director
Vriendschap Village
2602 Fifield Road
Pella, IA 50219

**RE: Final Complaint/Incident Investigation Report, Vriendschap Village, Pella, Iowa**

Dear Ms. Colvin:

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 Insufficiencies, DIA accepts the POC.

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

# IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
## Assisted Living Program
## Final Complaint/Incident Investigation Report

**Assisted Living Program:**

Vriendschap Village
Brenda Colvin, Director
2602 Fifield Road
Pella, IA 50219

**Complaint/Incident Intake #:**

43437-C

**Date of Complaint/Incident Investigation:**

May 1, 2013

**Monitor(s):**

Joyce Kix, RN

**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: | 24 |
| Number of tenants with cognitive disorder: | 4 |
| Total Population of Program at time of on-site | 28 |

| Dementia-Specific Program by Dedication | |
|---|---|
| Number of tenants without cognitive disorder: | 0 |
| Number of tenants with cognitive disorder: | 4 |
| Total Population of Program at time of on-site | 4 |

| | |
|---|---|
| **TOTAL census of Assisted Living Program** | 32 |

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

**Complaint/Incident Investigation** – The Complaint/Incident investigator made the observations detailed in the following areas:

### A. Tenant Rights

Complaint/Incident Allegation: It was alleged that a tenant was smoking cigarettes near the program and the smoke was entering the memory care unit dining room. It was also alleged that a tenant was missing some personal items from his/her apartment.

Monitoring Observation: The policy provided by the Director indicated the program was smoke free inside the building and on the grounds for staff members. The Occupancy Agreement noted, "No smoking in any apartment or any common areas permitted." The Director reported there was one tenant who smoked outside the door of the Memory Care Unit. Staff members reported that smoke entered the unit and the tenant was asked to leave the property to smoke; however, when the weather was cold or raining, the tenant stayed near the building to smoke. Three months of Tenant Council minutes were reviewed with no mention of concerns regarding smoking. No tenants reported concerns of smoking odors and the tenant who smoked moved from the program voluntarily 4-30-13.

Tenant Council minutes for three months were reviewed. There were no concerns of theft or missing personal items mentioned. Staff #1, #2, #3 and #4 were interviewed with no concerns mentioned regarding theft of tenant possessions. One tenant interviewed stated he/she had never had any missing personal items and had no concerns regarding theft or safety in the building.

Regulatory Insufficiency: None noted.

**B. Nurse Review**

Complaint/Incident Allegation: It was alleged a staff member called the director for assistance when a tenant was experiencing pain and a nurse did not return the call with directions.

Monitoring Observation: During interview, the Director stated that the Registered Nurse (RN) had left employment on 4-4-13. The Director provided documentation of nursing coverage for on-call for the month of April. A Licensed Practical Nurse (LPN) from another corporate program provided coverage for the weekend beginning 4-5-13 to 4-8-13. The Director was not aware of any instances when the nurse was not available by phone. An RN already working at the program was taking on-call for the rest of April except 4-27 and 4-28-13 when the LPN took calls again. An RN was hired to begin in May and would take over on-call.

During interview, Staff #5, an LPN, reported she was on call for the weekend of 4-5-to 4-8-13. She was unfamiliar with the tenants of the program but had obtained a book from the program with tenant specific information. Staff #5 reported she had been at the program on 4-5-13 but had not been back since then. She remembered receiving a call on 4-6-13 when she advised the program staff member to call family and have them transfer a tenant out but she did not remember any other calls that weekend. She reported she did not document the calls and did not remember who made the calls or what the tenants' names were.

During interview, Staff #1 reported that on 4-7-13 a tenant reported pain not relieved by prescribed medications and she placed a call to the Director as was the protocol. Prior to Staff #1 leaving her shift, she did not receive a call back from the Director or the nurse. Staff #1 applied ice packs to the tenant's back and the tenant reported relief.

During interview, Staff #2 reported she was not aware of any instances when the nurse was not available by phone. Staff #3 stated a nurse had always been on call when she needed her but she had heard of one instance when the nurse did not call back immediately. Staff #3 was not sure of the specifics. Staff #4 reported knowledge of no incidents when the nurse was not available on call.

Tenant #2, a 92 year old, was admitted 8-14-10 with diagnoses of: Hypertension, Diabetes, Atrial Fibrillation, Congestive Heart Failure, Hyperlipidemia and Parkinson's Disease. According to the Resident Notes dated 3-26-13, Tenant #2 returned from a stay at a nursing home. On 3-27-13 the notes indicated Tenant #2 was very slow and fell asleep at the supper table. The notes continued on 4-10-13 with orders for an antibiotic for a urinary tract infection and ice packs to the back for discomfort. On 4-12-13 the oral antibiotic was discontinued and intravenous antibiotics were initiated by a home health agency for nine days. On 4-14-13 the notes documented Tenant #2 required two staff members to transfer to the toilet during the night. The physician ordered Hydrocodone for pain. The clinical record lacked documentation of completion of a nurse review with the changes noted by staff in Tenant #2's health status.

Tenant #3, an 89 year old, was admitted to the memory care unit 3-23-13 with a diagnosis of Diabetes. The Global Deterioration Scale (GDS) dated 3-19-13 documented Tenant #3 scored "3" which indicated mild cognitive decline. The last noted documentation completed by a nurse found in the tenant notes was dated 3-26-13 and indicated Tenant #3 was settling in the memory care unit, talking appropriately with staff and participating in activities. According to the Director, Tenant #3 went out to the hospital on 4-4-13 and returned to the program on 4-5-13. Staff #5, an LPN, was present at the program when Tenant #3 returned. Staff #5 said Tenant #3 was "out of it" and it took three staff to get him/her to the bathroom. Staff #5 completed a health assessment and advised the staff present to check on the tenant frequently, and use two people and a gait belt to transfer if necessary. Tenant #3 was not to get up independently. Staff #5 left the program and reported receiving a call the 4-6-13 about Tenant #3 with information that Tenant #3 was not waking up. At that time, Staff #5 advised staff to contact Tenant #3's family and have them transfer the tenant out. Unlicensed staff members do not document at the program so there was no evidence of assessment to be reviewed regarding Tenant #3 from the time Staff #5 left on the evening of 4-5-13 to the time Tenant #3 was transferred out. The family took Tenant #3 to the hospital and Tenant #3 has since died without returning to the program.

Regulatory Insufficiency: If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation to assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

During the course of the investigation, the following information was identified.

**C. Evaluation**

Monitoring Observation: According to the Resident Notes dated 3-26-13, Tenant #2 returned from a stay at a nursing home. On 3-27-13 the notes indicated Tenant #2 was very slow and fell asleep at the supper table. The notes continued on 4-10-13 with orders for an antibiotic for a urinary tract infection and ice packs to the back for discomfort. On 4-12-13 the oral antibiotic was discontinued and intravenous antibiotics were initiated by a home health agency for nine days. On 4-14-13 the notes documented Tenant #2 required two staff members to transfer to the toilet during the night. The physician ordered Hydrocodone for pain. The clinical record lacked documentation of completion of functional and health evaluations with the changes noted by staff in Tenant #2's health status.

The clinical record for Tenant #3 contained the last noted documentation completed by a nurse dated 3-26-13 which indicated Tenant #3 was settling in the memory care unit, talking appropriately with staff and participating in activities. According to the Director, Tenant #3 went out to the hospital on 4-4-13 and returned to the program on 4-5-13. Staff #5, an LPN, was present at the program when Tenant #3 returned. Staff #5 said Tenant #3 was "out of it" and it took three staff to get him/her to the bathroom. Staff #5 said she completed an assessment and advised the staff present to check on the tenant frequently and use two people and a gait belt to transfer if

necessary. Tenant #3 was not to get up independently. Staff #5 left the program and reported receiving a call the next day about Tenant #3 with information that Tenant #3 was not waking up. At that time, Staff #5 advised staff to contact Tenant #3's family and have them transfer the tenant out. Unlicensed staff members do not document at the program so there was no evidence of assessment to be reviewed regarding Tenant #3. The family took Tenant #3 to the hospital and Tenant #3 has since died without returning to the program. The clinical record lacked evidence of completion of the required functional and cognitive evaluations completed with the identified changes in health status.

Tenant #4, an 88 year old, was admitted 12-17-12 with diagnoses of: Bleeding Stomach Ulcer and History of Hip Fracture. The clinical record lacked evidence of completion of health and functional evaluations at 30 days after occupancy.

Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive health status within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

**D. Service Plans**

Monitoring Observation: Tenant #1, a 71 year old, was admitted 9-27-12 with a diagnosis of Fall with Mental Status Changes. The Nursing Progress Notes dated 10-8-12 documented Tenant #1 was smoking on the program grounds and was advised the property was non-smoking. Tenant #1 continued to smoke outside the building. The service plan dated 10-26-12 failed to include interventions to address smoking. Tenant #1 continued to smoke until his voluntary discharge on 4-30-12.

According to the Resident Notes dated 3-26-13, Tenant #2 returned from a stay at a nursing home. On 3-27-13 the notes indicated Tenant #2 was very slow and fell asleep at the supper table. The notes continued on 4-10-13 with orders for an antibiotic for a urinary tract infection and ice packs to the back for discomfort. On 4-12-13 the oral antibiotic was discontinued and intravenous antibiotics were initiated by a home health agency for nine days. On 4-14-13 the notes documented Tenant #2 required two staff members to transfer to the toilet during the night. The physician ordered Hydrocodone for pain. The clinical record lacked documentation of up-dates and inclusion of outside providers to Tenant #2's service plan with the changes noted in health status.

The clinical record for Tenant #3 contained the last noted documentation completed by a nurse dated 3-26-13 which indicated Tenant #3 was settling in the memory care unit, talking appropriately with staff and participating in activities. According to the Director, Tenant #3 went out to the hospital on 4-4-13 and returned to the program on 4-5-13. Staff #5, an LPN, was present at the program when Tenant #3 returned. Staff #5 said Tenant #3 was "out of it" and it took three staff to get him/her to the bathroom. Staff #5 said she completed an assessment and advised the staff present to

check on the tenant frequently, and use two people and a gait belt to transfer if necessary. Tenant #3 was not to get up independently. Staff #5 left the program and reported receiving a call the next day about Tenant #3 with information that Tenant #3 was not waking up. The clinical record lacked evidence of completion of an up-dated service plan with the identified changes in health status and functional abilities noted by staff.

Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22 (1) and 69.22 (2) and shall be designed to meet the specific needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26 (1))

**E. Tenant Documents**

Monitoring Observation: The clinical record for Tenant #3 contained the last noted documentation completed by a nurse dated 3-26-13 which indicated Tenant #3 was settling in the memory care unit, talking appropriately with staff and participating in activities. According to the Director, Tenant #3 went out to the hospital on 4-4-13 and returned to the program on 4-5-13. Staff #5, an LPN, was present at the program when Tenant #3 returned. Staff #5 said Tenant #3 was "out of it" and it took three staff to get him/her to the bathroom. Staff #5 said she completed an assessment and advised the staff present to check on the tenant frequently, and use two people and a gait belt to transfer if necessary. Tenant #3 was not to get up independently. Staff #5 left the program and reported receiving a call the next day about Tenant #3 with information that Tenant #3 was not waking up. At that time, Staff #5 advised staff to contact Tenant #3's family and have them transfer the tenant out. Unlicensed staff members do not document in the clinical record so there was no evidence of assessment to be reviewed regarding Tenant #3 from the time Staff #5 left on 4-5-13 to the time Tenant #3 was transferred out again. The family took Tenant #3 to the hospital and Tenant #3 has since died without returning to the program. The clinical record lacked documentation of any assessment, intervention or condition changes after Staff #5 left on the evening of 4-5-13 until Tenant #3 was transferred from the program 4-6-13.

Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and include: (i) when any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception. (IAC r. 481.69.25(1), i )