IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 46196-I

November 25, 2013

Ms. Inde Miller, Executive Director
Vriendschap Village
2602 Fifield Road
Pella, IA 50219

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

Dear Ms. Miller:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of November 18 and 19, 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:

Inde Miller, Executive Director
Vriendschap Village
2602 Fifield Rd.
Pella, Iowa 50219

Complaint/Incident Intake #:

46196-I

Date of Complaint/Incident Investigation:

November 18 and 19, 2013

Monitor(s):

Maribeth Freland 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:	25
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	29
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	7
TOTAL census of Assisted Living Program	36

Program History – The program has not received any regulatory insufficiencies during this certification period.

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

Medications

Complaint/Incident Allegation: It was reported staff members gave a tenant medications not ordered for the tenant, resulting in the tenant needing to be hospitalized.

- Monitoring Observation: The monitor reviewed medication error reports for September, October and November 2013. The program had four medication omissions in September involving four tenants (including Tenant #1), four medication omissions in October involving two tenants (including Tenant #2.), two tenants received a double dosage of medication in October (Tenant #1 and #3)and one tenant received another tenants medications in November (Tenant #4).

  The monitor reviewed the clinical records of Tenants #1, #2, #3 and #4 finding the following:

  Medication error reports indicated Tenant #1 did not receive his/her 5:00 p.m. medications on 9-6-13 and received two Tramadol tablets in the morning instead of one tablet on 10-21-13. Tenant #1's clinical record indicated Tenant #1 took Ranitidine for Gastro-esophageal Reflux at 5:00 p.m. The clinical record also indicated Tenant #1 was to receive Tramadol (a pain reliever) one 50 milligram (mg) tablets each morning. Tenant #1 did not receive his/her Ranitidine on 9-6-13. Tenant #1 had no documented gastrointestinal effects from the missed medication. Tenant

#1 received two 50 mg tablets of Tramadol on 10-21-13 with no adverse effects. The program notified Tenant #1's physician with each medication error.

Medication error reports indicated Tenant #2 did not receive his/her 2:00 p.m. medications on 10-12-13 and 10-13-13. Tenant #2's clinical record indicated Tenant #2 took Tylenol Arthritis 650 mg and Tramadol 100 mg at 2:00 p.m. Tenant #2 had no documented increased discomfort from the missed medications. The program notified Tenant #2's physician with each medication error.

Medication error reports indicated Tenant #3 received two 1 mg. Clonazepam tablets at bedtime, one by two different direct care workers on 10-12-13. Tenant #3's clinical record indicated Tenant #3 took Clonazepam (a sedative) 1 mg at bedtime. Tenant #3 was administered two 1 mg tablets of Clonazepam on 10-12-13. Tenant #3 had no documented over-sedation from the double dosing of the sedative. The program notified Tenant #1's physician with each medication error.

Tenant #4, an 88 year old, was admitted to the program on 11-6-13 and currently resided in the general population area of the program. Tenant #4 had diagnoses of Hypertension, Coronary Artery Disease, Chronic Ischemic Heart Disease and Monoclonalgammopathy of Unknown Significance. Tenant #4 answered all questions correctly on the program's cognitive assessment, indicating no cognitive impairment. Tenant #4 was independent with all activities of daily living, requiring only medication assistance from program staff members. The program registered nurse set up Tenant #4's medications in a weekly planner and the program's direct care workers administered the medications multiple times daily from the weekly planner. Tenant #4 resided in the apartment with his/her spouse who also had medication administration in the same manner from the program registered nurse and direct care workers.

On 11-7-13, one day after admission to the program, Tenant #4 had a nose bleed that could not be stopped. The program sent Tenant #4 to the emergency room for medical evaluation and treatment on 11-7-13. Tenant #4 returned to the program later the same day.

On 11-8-13 Tenant #4 again experienced a nose bleed that could not be stopped. The program sent Tenant #4 to the emergency room again for medical evaluation and treatment on 11-8-13. Tenant #4's nose was packed with packing material and a balloon. Tenant #4 returned to the program later the same day with instructions to leave the packing and bulb in place until 11-12-13. Tenant #4 did not have any further nose bleeds between 11-8-13 and 11-12-13.

On 11-12-13 Tenant #4 went to visit his/her physician to have the packing and bulb removed and went back to the program. Later that evening Tenant #4's nose began to bleed uncontrollably again and was sent back to the emergency room for medical evaluation and treatment. Tenant #4's nose bled for approximately one hour. After the bleeding was brought back into control, Tenant #4 returned to the program with a plan to visit the physician the following day.

On 11-13-13 a direct care worker entered Tenant #4's apartment to administer Tenant #4's and his/her spouse's morning medications. The staff member inadvertently

administered the medications from Tenant #4's spouse's medication planner to Tenant #4. After Tenant #4 swallowed his/her spouse's medications, the direct care worker noted the error. Tenant #4 was given three blood pressure medications, one diuretic, one vitamin and one antidepressant that were prescribed to his/her spouse.

The program immediately notified the physician of the error and notified Tenant #4's family member who was listed for emergency notification. The program registered nurse directed the certified nursing assistants to monitor Tenant #4's blood pressure at least hourly. Tenant #4's blood pressure readings and other symptoms were as followed: 9:00 a.m. 103/65 with no symptoms of hypotension; 10:00 a.m. 100/70 with some report of lightheadedness when standing; 11:30 a.m. 107/62 without symptoms of hypotension; Tenant #4 walked to lunch and then went with his/her family member to the physician's office at 12:30 p.m. While at the physician's office, Tenant #4 had a syncopal episode and was taken to the emergency room. Tenant #4 was admitted to the hospital and diagnosed with anemia and hypoglycemia secondary to multifactorial anemia, recurrent nose bleeds and the medication error. Tenant #4's hemoglobin and hematocrit were low due to the recurrent nose bleeds so Tenant #4 was given two units of packed red blood cells. Tenant #4 was kept overnight at the hospital and sent back to the assisted living the following day.

During interview, Tenant #4's family member who attended the physician's appointment on 11-13-13 reported Tenant #4's recurrent nose bleeds had begun occurring prior to admission to the assisted living. During the hospitalization, the physician determined the nose bleeds were a result of a prescription nasal spray used to treat seasonal allergies. The nasal spray was discontinued while at the hospital and Tenant #4 had not had any nose bleeds since the hospitalization. Tenant #4 had no further issues with hypotension after the syncopal episode.

The program reported the medication error to the physician immediately, monitored Tenant #4's blood pressures following the medication error to identify any adverse reactions from the medication error. Tenant #4 was experiencing the recurrent nose bleeds with subsequent anemia which could also cause a syncopal episode. The program disciplined the certified nursing assistant who made the medication error, reviewed appropriate medication techniques with the assistant and other direct care workers and were looking into changing to a pharmacy system for medication administration in an attempt to decrease the risk of medication errors.

- Regulatory Insufficiency: None noted.