IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
46597-I
46769-C

March 6, 2014

Ms. Kathy Shriner, AL Director
Calvin Community Assisted Living
4210 Hickman Road
Des Moines, IA 50310

RE: Final Complaint/Incident Investigation Report, Calvin Community Assisted Living, Des Moines, Iowa

Dear Ms. Shriner:

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, following an investigation by DIA on **February 26 & 27, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Program Reporting to Department and Medications.

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 to DIA 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

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

Assisted Living Program: **Complaint/Incident Intake #:** 46597-I, 46769-C

Kathy Shriner, AL Director
Calvin Community Assisted Living
4210 Hickman Road
Des Moines, IA 50310

Date of Complaint/Incident Investigation:

February 26 & 27, 2014

Monitor(s):

Margaret Kaltefleiter, RN MS
Rose Boccella, 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.

General Population Program	
Number of tenants without cognitive disorder:	53
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	58
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	18
Total Population of Program at time of on-site	18
TOTAL census of Assisted Living Program	76

Program History – During the Recertification on-site of June 4 and 5, 2013, the program received regulatory insufficiencies in the areas of: Criteria for Admission and Retention, Staffing and Dementia Specific Education.

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

A. Program Reporting to the Department

- Monitoring Observation #46597-I: The Program reported Tenant #1 was given Tenant #2's medication planner, consumed some of the wrong medications and was sent to the Emergency Room (ER). Tenant #1 was later admitted to the hospital for treatment. Tenant #2 did not take any of Tenant #1's medications.

  Tenant #1, a 93 year old, was admitted on 11-28-12 and diagnoses include: Diabetes, Vision Difficulties, Urinary Difficulties, History of Bradycardia, Atrial Fibrillation, Hypertension (HTN) and Pancreatic Cancer (2-24-14). According to a Medication Error Report dated 12-15-13, medication boxes were given daily to two tenants. The wrong medication box was given to Tenant #1. The name on the box was correct but the medications were not. Tenant #1 was admitted to the hospital with Bradycardia and Hypotension. Tenant #1 originally complained of left arm pain.

  According to Resident Progress Notes dated 12-15-13 at 7:26 a.m., Tenant #1 was in bed sleeping, awakened easily and stated slept good. Tenant #1 complained of pain to left arm and left side. Denied any complaints of numbness or tingling. Vital signs: temperature 97.7, heart rate 44, blood pressure low 100/58. Tenant #1 refused to get

up, which was unusual for Tenant #1. Blood sugar was 109. At 8:00 a.m. the nurse checked on Tenant #1, still in bed sleeping, awakened easily. Tenant #1 stated was feeling tired and wanted to sleep. Blood pressure was 60/40 and heart rate was 40. Tenant #1 was encouraged to be evaluated at the ER. Tenant #1 agreed and the ambulance and Tenant #1's family was called. At 10:25 a.m. a Certified Medication Aide (CMA) brought the medication strip from Tenant #1's room for the day before and noticed four pills were left in the box. The nurse realized they were another tenant's medications and the ER nurse was notified. Tenant #1 was discharged from the hospital on 12-17-13. According to Resident Progress Notes dated 12-18-13 at 10:30 a.m., Tenant #1 had no change in condition as far as cognitive, functional or physical status. Tenant #1 was at baseline.

Tenant #2, a 76 year old, was admitted on 5-23-13 and diagnoses included: Diabetes Mellitus, Neuropathy, Chronic Pain, Vitamin Deficiency, HTN, Atherosclerosis, Esophageal Reflux, Keratosis, Memory Loss, Hyperlipidemia, Depressive Disorder and Dementia. According to Resident Progress Notes dated 12-15-13 at 7:17 a.m., Tenant #2 called the nursing office and stated medications were wrong. The CNA went to Tenant #2's room and noticed the medications were for someone else. She brought the medications to the charge nurse and medication strip was corrected. Tenant #2 did not take any medications from the medication strip. Tenant #2 was alert and knew all of Tenant #2's medications. A Medication Error Report indicated Tenant #2 called the nursing office and stated pills were wrong, medications were someone else's in the medication box. The nurse in charge gave the appropriate medications.

According to a Program document, on 12-14-13 Tenant #1 was given a medication box that was labeled with Tenant #1's name but contained the medications of another tenant. It was believed that during the weekly filling of the medication box, the 12-14-13 box was inadvertently placed into another tenant's pill planner (and vice versa) and was filled with another's medications at that time and when the planner was handed to Tenant #1 the wrong set of medications were taken. Tenant #2 noticed the pills were wrong and did not take the pills and alerted staff immediately. The charge nurse followed up with Tenant #2 and corrected the medication error. She was not aware that Tenant #1 had been given Tenant #2's medication until after Tenant #1 went to the hospital. At that time she immediately called the ER and informed them of the situation.

After the incident, the Program had already decreased the number of tenants that received medications via a daily medication strip to four and with the tenants agreement the Program had now chosen to eliminate this option of medication delivery.

The AL Manager was interviewed and stated Tenant #1's medications were labeled and filled correctly but accidently given to Tenant #2 and Tenant #2's medications were given to Tenant #1.

The LPN stated she was working the weekend as the charge nurse and there were five tenants with medication boxes which were left in the tenant's room. On Saturday, Tenant #2 called and said the pills were wrong and Tenant #2 did not take any. She checked the medications and they were wrong so she got him the correct medications.

On Sunday, Tenant #1 had not called so she checked on Tenant #1 who didn't feel well and wanted to sleep. Tenant #1's blood pressure was 100/58 and pulse was 44. Tenant #1 was not normal self, just wanted to sleep. Normally Tenant #1 was up between 6:00 a.m. and 6:30 a.m., dressed self and checked own blood sugar. She returned 20 minutes later to follow-up with Tenant #1; blood pressure was 60/40 and pulse was between 33 and 40. She called Tenant #1's family and called an ambulance. Later the CMA said a couple pills were left from the previous day in the medication planner in Tenant #1's room. As soon as she figured out what happened, around 10:00 a.m., she notified the ER.

Tenant #1 was interviewed and stated in the middle of December was given the wrong medications and went to the ER. Tenant #1 was kept in the hospital for about three days and the issue had been resolved. The Program changed how they distributed medications. They used to have medication strips that were delivered every morning. The wrong medications were put in the evening slot. Now medications were provided individually so some good came from the incident. Staffs now observed Tenant #1 take the medications.

Tenant #2 was interviewed and stated Tenant #2 was treated really well and liked the people that helped. Tenant #2 loved living at the Program and staff responded within 5 to 10 minutes when called for assistance. Medications were administered to Tenant #2 and three excellent meals a day were provided. Lots of activities were provided in the main lounge such as movies, music and other programs. Tenant #2 did not remember any issue with medications, thought one of the nurses mentioned it but it certainly wasn't a big issue.

An incident report was completed on 12-15-13. The Department was notified on 12-24-13.

Tenant file reviews and interviews with tenants, staff, the LPN and AL Manager indicated medications for one day were mixed up between two tenants. Tenant #1 took some of the medications; Tenant #1's blood pressure and heart rate decreased and Tenant #1 was sent to the ER. Tenant #2 identified the medications were incorrect, did not take any of the pills, notified staff and the medications were corrected. The incident occurred on 12-15-13 and the Department was notified on 12-24-13. The Department was not notified within 24 hours or the next business day.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury. "Major injury" shall be defined as any injury which: requires admission to a higher level of care for treatment, other than for observation. (IAC r. 481-67.4((1)(a)(2))

B. Medications

Complaint/Incident Allegation #46769-C: It was alleged staff were forced to give tenants pain medications even if the tenants did not want them. It was alleged a nurse instructed staff to give as needed medications even when the tenants stated they were not in pain.

- Monitoring Observation: Interviews were conducted with six staff, the RN and AL Manager.

  Staff #2, #3, #4, #5, #6 and the AL Manager were interviewed and stated staff was not forced to give tenants pain medications even if the tenant did not want them. The RN stated there was a time when staff was told to give as needed medications every eight hours after a fall. She was teaching staff how to recognize non-verbal cues in the dementia unit, such as grimacing.

  Staff #2, #3, #4, #6, the RN and the AL Manager were interviewed and stated staff was not giving as needed medications even when the tenants stated they were not in pain. The RN stated when as needed medications were needed staff called the nurse. Staff was to call the RN or LPN for direction when tenants asked for as needed medications.

  Per staff, RN and AL Manager interviews there was no indication of staff being forced to give tenants pain medications even if the tenants did not want them and staff did not give tenants as needed medications when the tenants were not in pain.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #46769-C: It was alleged falls and injuries had occurred due to tenants taking pain medications.

- Monitoring Observation: Incident reports were reviewed for three months prior to the onsite monitoring investigation visit. There were no incident reports for fall or injuries that were caused by tenants taking pain medications.

  Staff #2, #3, #4, #5, #6 and the RN were interviewed and stated tenants had not fallen due to taking pain medications. The AL Manager was interviewed and stated it was possible that tenants could have fallen due to taking pain medications but she was not aware this had happened.

  Review of incident reports and interviews with staff, the RN and AL Manager did not indicate any falls or injuries had occurred due to tenants taking pain medications.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation #46769-C: It was alleged untrained nurse aides were directed to count narcotics with medication managers (MM).

- Monitoring Observation:

  Staffs #2, #3 and #4 stated untrained CNA's were not directed to count narcotics with medication managers. Staff #5 stated it happened once when a nurse was standing there and instructed a MM to count narcotics with Staff #6 who was a CNA. Staff #6 stated she counted narcotics two times when a former nurse told her to do it. The former nurse was standing by the desk. Staff #6 was working in the dementia unit alone for about one hour. At shift change the former nurse told her to do it. She

asked the former nurse three times if she should do this and the former nurse insisted that she should count the narcotics. The count was correct. The LPN stated the narcotic counts were performed by a nurse and a CMA or two CMA's. She stated CNA's did not count narcotics. The RN stated she had just learned that day there were three incidents where a CNA was directed by another nurse to count narcotics with another staff. That nurse no longer worked at the Program. The AL Manager was interviewed and initially stated narcotic counts were not completed with CNA's but with CMA's or MM's. They would count with each other. Later the AL Manager stated Staff #6 had signed off two times on Narcotic Sign Off sheets with a former nurse right there. Staff #7, who was in a CMA class, had also signed off one time on the narcotics count. The AL Manager stated this was not their practice and Staff #6 was directed by a nurse who no longer worked there.

The AL Manager provided a written statement dated 2-27-14 that indicated the Program's current procedure involved having two staff members working in the memory unit perform the narcotic count at the end of each shift. The two staff could be an RN, LPN, CMA or MM. The exiting policy stated there must be an RN or LPN with a CNA or CMA. The policy on Medication Administration would be updated to reflect the current practice.

Review of Scheduled Drug Shift Count sheets for three months indicated Staff #6, a CNA, signed off on the narcotics count on 1-4-14 at 2:00 p.m. and at 10:00 p.m. On 12-30-13 at 2:00 p.m., Staff #7, a CNA, signed off on the narcotics count.

According to the Narcotic Administration In Assisted Living Policy, each shift the narcotics would be counted by two individuals. The drug count must be done by an RN or LPN in conjunction with a second staff person (RN, LPN or CMA). The individuals counting medications would sign the narcotic count sheet and include the date and time.

The monitor observed the narcotics count in the dementia unit on 2-26-14 at 1:48 p.m. by Staffs # 3 and #4, both CMAs. Staffs #3 and #4 signed the Shift Drug Count For Scheduled Narcotics.

Review of Scheduled Drug Shift Count sheets and interviews with staff, the LPN, RN and AL Manager indicated CNAs had counted narcotics. Per Program policy, the drug count must be done by an RN or LPN in conjunction with a second staff person (RN, LPN or CMA). The Program did not follow their policy for Narcotics Administration.

- Regulatory Insufficiency: Each program shall follow its own written medication policy, which shall include the following: When medications are administered traditionally by the program: The administration of medication shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67-9(4) or a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant.