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 #: 48414-C

August 18, 2014

Ms. Inde Miller, Executive Director
Vriendschap Village
2604 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 August 6 & 11, 2014, 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 #:** 48414-C

Inde Miller, Executive Director
Vriendschap Village
2604 Fifield Road
Pella, IA 50219

Date of Complaint/Incident Investigation:

August 6 and 11, 2014

Monitor(s):

Stephanie Cummins, MA

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:	26
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	30
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	6
TOTAL census of Assisted Living Program	36

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

A. Tenant Documents

Complaint/Incident Allegation: It was alleged a tenant who had alarms for fall prevention fell and staff was directed to document the alarm checks even if the alarms had not been checked. It was alleged staff was given a timeframe to return to the building to falsify the documentation.

- Monitoring Observation: Four tenant files were reviewed. The tenant files included both current and discharged tenants. According to the Nurse there were no current tenants with a pad alarm.

  Review of four tenant files (Tenants #1, #2, #3 and #4) indicated Tenant #2 was the only tenant who had a pad alarm.

  Tenant #2, a 92 year old, was admitted on 8-17-13 and diagnoses included: Left Femoral Neck Fracture Status/Post Left Hip Replacement, Aspiration Pneumonia, Dementia, Gastro Esophageal Reflux Disease and Vitamin B12 Deficiency. Tenant #2 was staged at a six on the Global Deterioration Scale (GDS) on 5-13-14, which indicated severe cognitive decline. Tenant #2 had resided in the dementia unit and was discharged.

  According to an incident report, the incident occurred in Tenant #2's apartment, on 4-20-14 at 6:30 a.m. Tenant #2 had gotten up from the bed and was walking to sit on a chair by the doorway and missed the chair as Tenant #2 was going to sit. Tenant #2 fell onto the floor. Tenant #2 had left side hip pain and was taken to a hospital. According to a hospital discharge summary, Tenant #2 had a fall with displaced femoral neck fracture and was admitted. The service plan dated 4-10-14 indicated

Tenant #2 needed cues during transfers in the common areas and was independent in the apartment. The service plan indicated to ensure Tenant #2 had the walker at all times. Tenant #2 was staged at a four on the GDS on 2-20-14, which indicated moderate cognitive decline.

According to a nurse review dated 5-16-14 Tenant #2 returned to the Program from the hospital after having a left hip revision. Tenant #2 was an assist of one with transfers and ambulation and received medication management. The service plan dated 5-13-14 indicated Tenant #2 had a pad alarm to the bed and chair.

According to an incident report, the incident occurred on 5-16-14 at 11:00 p.m. in Tenant #2's apartment. Tenant #2's alarm went off and Tenant #2 was sitting on the floor next to the bed. There were no injuries noted.

A document from the Nurse indicated Tenant #2 was transferred to the emergency room (ER) on 5-20-14 and was diagnosed with a Urinary Tract Infection and had bilateral tremors and low blood pressure. Tenant #2's family felt it was best to transfer Tenant #2 to long term care while there was an opening.

Tenant #2 did not return to the Program after being transferred to the ER on 5-20-14.

A Resident Service Delivery Daily Record for Tenant #2 reflected alarm checks (bed and chair/recliner) were started on 5-16-14. The document indicated the alarms were checked once per shift. Staff consistently documented the checks from the second shift on 5-16-14 through the third shift on 5-20-14.

Staff #1 said there were no current tenants with pad alarms. She said Tenant #2 had pad alarms. The alarms were checked every shift and she usually did the check when she started her shift. She said the checks were documented appropriately. Staff #1 said staff had not been directed to falsify any records including alarm checks. She was not aware of any staff that documented an alarm check when it was not completed.

Staff #2 said there were no current tenants with pad alarms. She said Tenant #2 had a pad alarm, it was checked several times per shift and the checks were documented. She said the checks appeared to be documented appropriately. Staff #2 said staff had not been directed to falsify any records including alarm checks.

Staff #3 said there were no current tenants with pad alarms. She said the alarm for Tenant #2 was checked at the beginning of the shift to ensure it was working. The alarm checks were documented appropriately. Staff #3 said staff had not been directed to falsify any records including alarm checks. Staff did not document the alarm checks when the checks were not completed.

The Nurse said there were no current tenants with pad alarms. She said Tenant #2 had a pad alarm for the bed and chair. Staff checked the alarms once per shift with no specific times during the shift. Staff documented the checks and the checks were documented appropriately. The Nurse said staff had not been directed to falsify any records including alarm checks. The Nurse said staff did not document alarm checks when the checks were not completed.

The Executive Director (ED) said Tenant #2 had a pad alarm for a short time. She said staff had not been directed to falsify any records including alarm checks.

According to a Program policy, all of the tenants had documentation on their Medication Administration Record/Treatment Administration Record (MAR/TAR) in a timely manner to ensure accuracy and completeness. According to the procedure, during the shift to shift report between staff, the oncoming staff would review the MARs/TARs to assess for omissions and/or discrepancies. If an omission was identified on a MAR/TAR and the staff responsible was not on duty at the time of the discovery, the staff would have up to 72 hours to complete the documentation if they could assure the medication/treatment was administered. When an omission was identified the staff identifying the issue was to notify the supervisor and immediate contact with the staff responsible would be attempted to see if the medication or treatment was given. If the staff responsible for the omission was unable to be reached within 2 hours of the end of the shift in which the omission occurred, the omission would be treated as an error. If the staff could not specifically recall the administration it would be treated as a medication error. If the staff responsible for the omission recorded the medication or treatment any time after the shift had ended but within 72 hours of when the medication or treatment was to be given, it would entered as a late entry.

Review of tenant files and a policy, staff interviews and an interview with the Nurse and ED did not reveal concerns regarding falsification of alarm check records.

- Regulatory Insufficiency: None noted.

B. Other

Complaint/Incident Allegation: It was alleged administration threatened staff with termination if the Department was called.

- Monitoring Observation: Staff #1, #2 and #3 said staff had not been threatened by administration regarding notification of the Department. The ED and Nurse said staff had not been threatened by administration regarding notification of the Department.

  According to a Non-Retaliation Policy, the Program welcomed reports made in good faith by health professionals concerning any policy or practice they believed to have violated professional standards, were against the law and/or posed a substantial risk to health, safety or welfare of any tenant. The management staff of the Program guaranteed that no retaliatory action would be taken against health professionals making such a report to the community or appropriate regulatory agencies.

  Per staff interviews, interviews with the Nurse and ED and review of a policy there were no concerns revealed regarding retaliation against staff.

- Regulatory Insufficiency: None noted.