IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
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TERRY E. BRANSTAD
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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
50008-C

March 3, 2015

Ms. Susan O'Connell, Director
Calvin Community AL Services
4210 Hickman Road
Des Moines, IA 50310

RE: Final Complaint/Incident Investigation Report, Calvin Community AL Services, Des Moines, Iowa

Dear Ms. O'Connell:

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 10, 11, 12 and 20, 2015.**

There were no regulatory insufficiencies identified related to the investigation of Complaint #50008-C; however, during the course of the complaint investigation regulatory insufficiencies were cited.

The following allegation was investigated in regards to Complaint #50008-C:
Allegation: Medication Administration

Findings: Unsubstantiated

Comments: Based on staff interviews, observation of a medication pass, review of three tenant files and review of Program documents there were no concerns identified regarding the routine availability of tenant medications. Staff interviews indicated there were no negative outcomes for tenants related to medication errors or unavailability of medications. Two of three tenant files reviewed had entries noted on the medication administration records regarding medications not available to administer. The unavailability of medications was related to external factors. Documentation and staff interviews revealed the Program tried to resolve the external issues to ensure

appropriate and timely delivery of the medications. The issue with the availability of the medications did not appear to be routine in nature or as a result of the Program not following applicable medication policies and procedures.

The Report notes Regulatory Insufficiencies in the area(s) of: Occupancy Agreement, Evaluation of Tenant and Service Plans.

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/emailed to DIA to my attention 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

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0057	A. BUILDING. _____ B WING _____	C 02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVIN COMMUNITY AL SERVICES	4210 HICKMAN ROAD DES MOINES, IA 50310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site General Population Program Number of tenants without cognitive disorder: 43 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 47 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 19 Total Population of Program at time of on-site: 19 TOTAL census of Assisted Living Program: 66 No regulatory insufficiencies were cited related to the investigation of Complaint #50008-C. During the course of the complaint investigation the following regulatory insufficiencies were cited: Iowa Code 231C.5(1) An assisted living program shall not operate in this state unless a written occupancy agreement, as prescribed in subsection 2, is executed between the assisted living program and each tenant or the tenant's legal representative, prior to the tenant's occupancy, and unless the assisted living program operates in accordance with the terms of the occupancy agreement. The assisted living program shall deliver to the tenant or the tenant's legal representative a complete copy of the occupancy agreement and all supporting documents and attachments and shall deliver, at	A 000		

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A 000	Continued From page 1 least thirty days prior to any changes, a written copy of changes to the occupancy agreement if any changes to the copy originally delivered are subsequently made. This requirement is not met as evidenced by: Based on review of a tenant file, Program documents and a staff interview, the Program was working on discharging Tenant #1, at the time of the investigation, due to Tenant #1 being a danger to self, other tenants and staff. A 30 day written notice for termination of the occupancy agreement had not been given to Tenant #1 as indicated in the occupancy agreement. 1. Tenant #1, an 82 year old, was admitted on 2-28-11 and diagnoses included: osteoarthritis, dementia and hypertension. Tenant #1 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit. 2. Resident Progress Notes from 11-1-14 to 1-23-15 were reviewed and indicated the following: Tenant #1 had behaviors, increased edema, increased pain, falls, low blood sugars and medication changes. Tenant #1 was hospitalized in December 2014 and January 2015 after incidents of aggressive behavior. Review of Resident Progress Notes from 1-26-15 to 2-10-15 indicated Tenant #1 remained in the hospital and had not returned to the Program 3. According to the Program's Assisted Living Memory Unit Program Tenant Agreement (occupancy agreement) signed by Tenant #1's legal representative, the Program could terminate the occupancy agreement at any time upon a 30 day written notice to the tenant. The Program had a policy of terminating the occupancy	A 000		

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A 000	Continued From page 2 agreement, at its discretion, if certain events occurred, which included when a tenant was dangerous to self, other tenants or staff. 4. According to an interview with the Director of Assisted Living (AL) on 2-11-15 at 1:15 p.m., there had been discussions regarding placement for Tenant #1; however, the attempts to find placement had been unsuccessful. The Director of AL said Tenant #1's family was working with the Program and it was not an involuntary transfer. According to an interview with the Director of AL on 2-12-15 at 11:05 a.m., a written 30 day notice had not been given to Tenant #1. 5. According to a statement from the Director of AL faxed on 2-16-15, the Program started actively working on placement for Tenant #1 in a Chronic Confusion and Dementing Illness (CCDI) unit on 11-24-14. It was discussed with Tenant #1's family and the search for placement was started. After Tenant #1's acute inpatient psychiatric stay in December 2014 the search for CCDI placement continued without success. The Director of AL indicated the Program did everything they could to find placement in a CCDI unit. Tenant #1's family was understanding and allowed the Program to help find placement. Tenant #1 would be placed in the health center after discharge from the hospital.	A 000		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant ' s functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each	A 037		

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A 037	Continued From page 3 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 when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on review of a tenant file and a Program document the Program failed to evaluate a tenant's health, functional and cognitive status as needed with significant change for one of three tenant files reviewed (Tenant #1). Evaluations were not completed as needed with significant change for Tenant #1 including for behaviors, increased edema, increased pain, falls, low blood sugars, medication changes and a hospitalization in December 2014. Evaluations were not completed as needed with significant change. 1. Tenant #1, an 82 year old, was admitted on 2-28-11 and diagnoses included: osteoarthritis, dementia and hypertension. Tenant #1 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit. 2. Resident Progress Notes from 11-1-14 to 11-30-14 were reviewed and indicated the following: Tenant #1 threatened to kill others, yelled and cursed at staff, threatened staff, had exit seeking behaviors and spit out medications. Tenant #1 had difficulty ambulating, increased	A 037		

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A 037	Continued From page 4 edema, a weight increase of 10 pounds in a week, low blood sugars and increased pain. Tenant #1 went into other rooms and would not let staff enter, attempted to hit staff and was found with a small piece of deodorant in Tenant #1's mouth. Tenant #1 voided on another tenant's floor, cut a placement with a knife, attempted to take apart another tenant's walker and tried to unzip Tenant #1's pants to void on the floor in the hall. Tenant #1 struck out at staff, refused cares, spit at staff and squeezed the arms of staff. At times Tenant #1 required two to three staff to transfer and provide activities of daily living. Tenant #1 entered other tenants', apartments and climbed into another tenant's bed (tenant was of the opposite sex). According to Resident Progress Notes on 12-2-14, while a nurse was pulling down Tenant #1's wet garments, Tenant #1 doubled up Tenant #1's fist and punched the nurse in the face. Tenant #1 was transferred to an emergency room (ER). According to Resident Progress Notes on 12-3-14, Tenant #1 was transferred to a geriatric psychiatry facility. Resident Progress Notes dated 12-12-14 indicated Tenant #1 returned to the Program. Resident Progress Notes dated 12-15-14 (90 day review) indicated Tenant #1 had many medication changes in the past quarter due to behavioral/aggressive problems. Seroquel was increased several times along with Ativan. Tramadol was increased and Aleve was added. Fentanyl was added to address acute and chronic back pain and Lantus was decreased due to decreased appetite. Tenant #1 continued to be aggressive and a danger to self and others despite the changes, according to the Resident	A 037		

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A 037	Continued From page 5 Progress Notes. Tenant #1 was transferred to an ER on 12-2-14 and then to a geriatric psychiatic unit on 12-3-14. Medication changes were made and Tenant #1 returned on 12-12-14. Some occasional verbal aggression continued. Tenant #1 had six falls in the past quarter. Resident Progress Notes from 12-15-14 to 1-20-15 were reviewed and indicated the following: Tenant #1 had falls, went into other tenant apartments, attempted to stab staff with a fork, shook a fist at staff and acted as if Tenant #1's hand was a gun. Tenant #1 was combative with staff during cares and exited through the fire doors with staff accompanying Tenant #1. Tenant #1 was agitated and could not be redirected or distracted and continued to get more agitated. A plastic bag full of urine was found inside Tenant #1's rectum. Tenant #1 was naked from the waist down and refused to put on clothes. Tenant #1 went into another tenant's room, refused to allow the other tenant to get in and attempted to fight the other tenant. Resident Progress Notes on 1-21-15 indicated another tenant reported Tenant #1 hit the other tenant. Resident Progress Notes dated 1-23-15 indicated Tenant #1 made verbal threats towards another tenant including pointing a "finger gun" at the tenant. Tenant #1 was transferred to an ER and was admitted. 3. Cognitive, health and functional evaluations were last completed on 3-10-14. 4. According to a statement from the Director of Assisted Living (AL) faxed on 2-16-15, Tenant #1's cognitive, health and functional status changed on a daily basis and sometimes hourly.	A 037		

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A 037	Continued From page 6 The Director of AL indicated she was working closely with staff but there was not a point where she could pinpoint a change in condition. The standard forms were not utilized during that time; however, Tenant #1 was assessed and staff was made aware of how to meet the needs of Tenant #1 as the changes occurred.	A 037		
A 085	481-69.26(3) Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant ' s occupancy and as needed with significant change, but not less than annually. This REQUIREMENT is not met as evidenced by: Based on review of a tenant file and a Program document the Program failed to update a service plan as needed with significant change for one of three tenant files reviewed (Tenant #1). The service plan was not updated as needed with significant change for Tenant #1 including for behaviors, increased edema, increased pain, falls, low blood sugars, medication changes and a hospitalization in December 2014. 1. Tenant #1, an 82 year old, was admitted on 2-28-11 and diagnoses included: osteoarthritis, dementia and hypertension. Tenant #1 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline Tenant #1 resided in the dementia unit. 2. Resident Progress Notes from 11-1-14 to 11-30-14 were reviewed and indicated the	A 085		

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A 085	Continued From page 7 following: Tenant #1 threatened to kill others, yelled and cursed at staff, threatened staff, had exit seeking behaviors and spit out medications. Tenant #1 had difficulty ambulating, increased edema, a weight increase of 10 pounds in a week, low blood sugars and increased pain. Tenant #1 went into other rooms and would not let staff enter, attempted to hit staff and was found with a small piece of deodorant in Tenant #1's mouth. Tenant #1 voided on another tenant's floor, cut a placement with a knife, attempted to take apart another tenant's walker and tried to unzip Tenant #1's pants to void on the floor in the hall. Tenant #1 struck out at staff, refused cares, spit at staff and squeezed the arms of staff. At times Tenant #1 required two to three staff to transfer and provide activities of daily living. Tenant #1 entered other tenant apartments and climbed into another tenant's bed (tenant was of the opposite sex). According to Resident Progress Notes on 12-2-14, while a nurse was pulling down Tenant #1's wet garments, Tenant #1 doubled up Tenant #1's fist and punched the nurse in the face. Tenant #1 was transferred to an emergency room (ER). According to Resident Progress Notes on 12-3-14, Tenant #1 was transferred to a geriatric psychiatry facility. Resident Progress Notes dated 12-12-14 indicated Tenant #1 returned to the Program. Resident Progress Notes dated 12-15-14 (90 day review) indicated Tenant #1 had many medication changes in the past quarter due to behavioral/aggressive problems. Seroquel was increased several times along with Ativan. Tramadol was increased and Aleve was added. Fentanyl was added to address acute and chronic	A 085		

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A 085	Continued From page 8 back pain and Lantus was decreased due to decreased appetite. Tenant #1 continued to be aggressive and a danger to self and others despite the changes, according to the Resident Progress Notes. Tenant #1 was transferred to an ER on 12-2-14 and then to a geriatric psychiatry unit on 12-3-14. Medication changes were made and Tenant #1 returned on 12-12-14. Some occasional verbal aggression continued. Tenant #1 had six falls in the past quarter. Resident Progress Notes from 12-15-14 to 1-20-15 were reviewed and indicated the following: Tenant #1 had falls, went into other tenant apartments, attempted to stab staff with a fork, shook a fist at staff and acted as if Tenant #1's hand was a gun. Tenant #1 was combative with staff during cares and exited through the fire doors with staff accompanying Tenant #1. Tenant #1 was agitated and could not be redirected or distracted and continued to get more agitated. A plastic bag full of urine was found inside Tenant #1's rectum. Tenant #1 was naked from the waist down and refused to put on clothes. Tenant #1 went into another tenant's room, refused to allow the other tenant to get in and attempted to fight the other tenant. Resident Progress Notes on 1-21-15 indicated another tenant reported Tenant #1 hit the other tenant. Resident Progress Notes dated 1-23-15 indicated Tenant #1 made verbal threats towards another tenant including pointing a "finger gun" at the tenant. Tenant #1 was transferred to an ER and was admitted. 3. A handwritten service plan was developed on 3-10-14. The handwritten service plan was updated to a typed service plan and signed by the	A 085		

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A 085	Continued From page 9 Director of Assisted Living (AL) on 6-9-14. An update to the service plan was dated 2-5-15 and reflected Tenant #1 walked independently without a mobility device. 4. According to a Program document, the Director of AL indicated Tenant #1's cognitive, health and functional status changed on a daily basis and sometimes hourly. The Director of AL indicated she was working closely with staff but there was not a point where she could pinpoint a change in condition. The standard forms were not utilized during that time; however, Tenant #1 was assessed and staff was made aware of how to meet the needs of Tenant #1 as the changes occurred.	A 085		

Department of Inspection & Appeals Investigation Visit
February 10, 11, 12 and 20, 2015

"Preparation and submission of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This plan of correction is prepared and submitted solely because it is required under federal and state law."

Regulatory Insufficiency: An assisted living program shall not operate in this state unless a written occupancy agreement, as prescribed in subsection 2, is executed between the assisted living program and each tenant or the tenant's legal representative, prior to the tenant's occupancy, and unless the assisted living program operates in accordance with the terms of the occupancy agreement. The assisted living program shall deliver to the tenant or the tenant's legal representative a complete copy of the occupancy agreement and all supporting documents and attachments and shall deliver, at least thirty days prior to any changes, a written copy of changes to the occupancy agreement if any changes to the copy originally delivered are subsequently made.

"It is Calvin Community's policy to follow our occupancy agreement with tenant or tenant's legal representative regarding a thirty day notice when the occupancy agreement is terminated for reasons outlined in the occupancy agreement. Such as, a tenant is in need of a higher level of care. An involuntary transfer would only be initiated per policy if tenant or tenant's legal representative refuses to work with Calvin Community to find placement when a higher level of care is necessary for the tenant. "Tenant #1, referred to regarding this insufficiency, no longer resides at Calvin Community."
When a decision has been made that a 30 day notice is required to the occupancy agreement it will be done in writing and a copy will be left in residents chart. Because this decision can cause conflict with resident and/or family, it will be done with a formal meeting with Director and at least 1 other member of management. We will monitor this on a continuous basis and began on 3/9/15.

Regulatory Insufficiency: Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also 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. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change.

"It is Calvin Community's policy to evaluate tenants functional, cognitive and health status prior to admission, within 30 days of occupancy and with significate change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. This evaluation will be conducted by a healthcare professional (RN). A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. The evaluation of physical, functional and cognitive status will be written in resident progress notes by all Calvin licensed nurses and now will also be written by an RN on the following forms with significant change in condition Resident Summary Brigg's form 3692MF-10 Physical Assessment, Functional Assessment Brigg's form 3394, and Cognitive Assessment tool. "Tenant #1, referred to regarding this insufficiency, no longer resides at Calvin Community."

The Director and Patient Care Coordinator, both RN's will discuss each resident with a Hospitalization or change in status and assure that proper documentation is done. This will be done continuously and we started this process 3/9/15.

Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually.

"It is Calvin Community's policy to write a Service Plan prior to admission based on pre-admission assessment of physical, functional and cognitive assessments and input from resident and family to meet the needs of the new resident. The service plan shall be updated within 30 days of tenant's occupancy and as needed with significant change, but not less than annually. "Tenant #1, referred to regarding this insufficiency, no longer resides at Calvin Community."

Special notes to staff, ADL sheets and verbal communication related to changes in resident physical, functional and cognitive status will be written on the service plan in addition to the notes and verbal communication which staff need to keep abreast of res changing needs. We began this process 3/9/15 and will monitor continuously.

- ***See attached policies on <u>Evaluation of Residents in Assisted Living</u> and <u>Service Plans</u>***