Iowa Department of Inspections and Appeals
Assisted Living Program
AMENDED - Complaint Investigation Report

Assisted Living Program: **Complaint Intake #: 12206**

Gary Schmid, Director
Bickford Cottage
1100 Linden Drive
Marion, IA 52302

Date of Investigation:

April 22, 2005

Monitor(s):

Stephanie Cummins, SW, MA

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or 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 rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may re-visit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Bickford Cottage on April 22, 2005. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP) –

Current number of tenants without cognitive disorder:	17
Current number of tenants with cognitive disorder:	12
Total Population:	29

Dementia Specific Program (DSP) –

Current number of tenants in a DSP that holds itself out as providing specialized care in a dedicated setting:	7
Current number of tenants without cognitive disorder:	0
Total Population:	7

Accreditation Status – Not applicable.

Complaint History –There were substantiated complaints in the areas of criteria for exclusion of tenants and service plans during this certification period.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Evaluation of Tenant - The program evaluates each tenant's functional and cognitive abilities and health status and the determination of needed services as required. [321 IAC 25.23(1) and/or (2)]

- Monitoring Observation: During the course of the complaint investigation the following information was obtained. Tenant #1 was admitted on 3-6-05 and had a functional, cognitive and health status evaluation prior to taking occupancy. Within 30 days of taking occupancy the program evaluated the tenant's functional abilities but did not evaluate cognitive abilities and health status. The tenant displayed physically aggressive behaviors, unmanageable incontinence and had medication changes that occurred since taking occupancy and the tenant's cognitive abilities and health status were not re-evaluated. A nurse's note dated 4-14-05 or 4-4-05 was labeled a 30 day assessment *(handwriting too difficult to determine date).* This note stated the tenant continued to be uncooperative with toileting and showers and also addressed medication changes; however, it was not a complete assessment. Tenant #2 was admitted on 5-18-03, was later hospitalized for a hip fracture and discharged to a nursing facility on 12-31-04. The tenant was re-admitted on 4-12-05. A health assessment and two cognitive evaluations were completed on 4-11-05. A functional assessment prior to tenant taking occupancy could not be found.

- Regulatory Insufficiency: The program did not consistently evaluate each tenant's functional and cognitive abilities and health status prior to and within 30 days of taking occupancy and as needed with change in condition.

B. Criteria for exclusion of tenants - Program does not admit or retain tenants that require a higher level of care, unless a written exception has been applied for and approved. [321 IAC 25.23(3); 25.24]

Complaint Allegation: It was alleged the program retained tenants that required a higher level of care.

- Monitoring Observation: Tenant #1 was admitted on 3-6-05 with a diagnosis of Alzheimer's Disease and hypertension. The tenant was evaluated as a six on the Global Deterioration Scale (GDS) on 3-5-05. The RN used the GDS instead of another cognitive tool because the tenant does not speak. The program also completed a health and functional evaluation prior to the tenant taking occupancy. The health evaluation, dated 3-5-05, stated the tenant was incontinent of urine and occasionally incontinent of bowel and was occasionally awake at night. According to the service plan, dated 3-5-05, the tenant required physical assist with evacuation, assistance with food preparation, medication administration, dressing, toileting, grooming, hygiene, bathing and needed two hour checks at night. Staff interviews indicated tenant ate independently and was independent with mobility. The service plan identified the tenant as needing supervision throughout the day due to impairment of judgment and redirection when behavior was inappropriate. The Power of Attorney (POA), RN, Director and another staff member signed the service plan on 3-9-05. According to staff members this tenant was physically aggressive during cares including hitting and kicking. Staff reported that two staff members

assisted during cares with this tenant, one staff member to distract the tenant and the other staff member to perform the care. Communication logs indicated on 4-3-05 it took three nurses to take the tenant to the bathroom and the tenant kicked and punched throughout. The tenant was again resistant on 4-5-05. All three staff interviewed reported this tenant had been aggressive. The staff stated the tenant's behaviors had improved. A fax from the RN to the physician dated 4-6-05 stated the tenant was very anxious and unsettled and the Alprazolam .25 qid was not helping the tenant. The RN note stated the tenant was not sleeping much at night and very little during the day. The tenant had medication changes, initiated on 04-07-05, which included Alprazolam from .25 to .5 mg, Lexapro 10 mg and Namenda starter pack which was half way through the building dose at the time of the investigation. Communication notes also stated staff found urine on the floor on 4-19-05. Staff interviews indicate the tenant was toileted every two hours and was wet more often than dry. Staff also reported the tenant could not tell them when the tenant needed to use the bathroom because the tenant was non-verbal. Staff reported the tenant was incontinent of both bladder and bowel and had toileted in inappropriate locations. Staff reported the tenant had gone to the bathroom in one of the chairs and had a bowel movement on the bathroom floor. None of these incidents of aggressive behavior or incontinence were documented in the RN's notes.

- Tenant #1 had been identified as requiring a higher level of care than allowed in an assisted living program. Subsequent to the on-site the program provided input that the tenant has a new medication regimen resulting in overall improvement in the tenants health status.

C. Tenant Documents – Program maintains a complete file for each tenant containing all appropriate documentation. [321 IAC 25.27]

- Monitoring Observation: During the course of the complaint investigation the following information was obtained. Tenant #1, admitted on 3-6-05, had several documents signed by the POA. The program had a copy of the POA paperwork in the tenant's file. The documents signed by the POA included: code status statement, service plan, service assessment, orientation checklist, pharmacy agreement, occupancy agreement, resident authorization and release of medical information. Tenant #2, admitted 05-18-03, had a Durable Power of Attorney (DPOA) and paperwork was in the tenant's file. The tenant's DPOA had signed several tenant documents including the occupancy agreement, resident information and photo release. The most current service plan was not signed by either the tenant or the tenant's legal representative. The DPOA had signed several documents; however, there was no statement from the tenant's physician indicating the tenant was unable to sign. Tenant #2 was hospitalized for a hip fracture and discharged to a nursing facility on 12-31-04. The tenant was re-admitted to the program on 4-12-05. Original physician order sheets stated the code status was full code and was dated 5-19-03. This order sheet now showed a scratch through the full code status and Do Not Resuscitate (DNR) was hand written on the top of the former code status with a date of 04-12-05. The tenant's physician did note on a program record that the tenant was a DNR. The program did not have a signed statement by the tenant or the tenant's DPOA that indicated the code status had changed from a full code to DNR.

- Regulatory Insufficiency: The program did not have appropriately signed tenant documents.

D. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. [321 IAC 25.28]

- Monitoring Observation: During the course of the complaint investigation the following information was obtained. Tenant #1 was admitted on 3-6-05 and had a service plan signed 3-9-05 by the RN, Director, POA, and another staff member. This plan was signed after the tenant had taken occupancy. The tenant did not have a service plan that was updated within 30 days of taking occupancy. Tenant #2 was admitted on 4-12-05 and had a service plan dated 4-12-05 signed only by the RN.

- Regulatory Insufficiency: The program did not have service plans developed prior to taking occupancy.

- Regulatory Insufficiency: The program did not have appropriately signed service plans.

Dated this 26th day of May 2005.

A. Regulatory Insufficiency: The program did not consistently evaluate each tenant's functional and cognitive abilities and health status prior to and within 30 days of taking occupancy and as need with change in condition.
Action Plan: Each tenant's functional and cognitive abilities and health status will be evaluated prior to, within 30 days of taking occupancy, and every 90 days and as needed with changes in condition. All new move ins will have assessments and service plans completed on the above schedule effective 4/28/05.

B. Program does not admit or retain tenants that require a higher level of care.
Action Plan: Bickford Cottage will evaluate each resident need, not retain residents who are inappropriate and for those who doe require a higher level of cares, work with family members on discharge criteria. See attached supporting documents that we disagree with findings regarding level of care for tenant #1.

C.Regulatory Insufficiency: The program did not have appropriately signed tenant documents.
Action Plan: All documents that are required will be signed upon admission and as needed effective 4/28/05.

D.Regulatory Insufficiency: The program did not have service plans developed prior to taking occupancy.
Action Plan: All new move in will have assessment and service plans completed prior to occupancy effective 4/28/05.
Regulatory Insufficiency: The program did not have appropriately signed service plans.
Action Plan: All service plans will signed by the required individuals by 4/28/05.