IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

July 28, 2009

Complaint #23844-C
#24114-C

Bonnie Smith, Administrator
Bickford Cottage of Marion
1100 Linden Dr.
Marion, IA 52302-7714

RE: Final Complaint Investigation Report, Bickford Cottage, Marion, IA

Dear Ms. Smith:

Enclosed is the **Final Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2007) and Iowa Administrative Code, chapters 321—25, pertaining to assisted living programs and 321—26, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. **No Regulatory Insufficiencies were identified.**

If you have questions, please contact me at 515-281-4116.

Sincerely,

Chris Nothaft
Certification Coordinator – Eastern Iowa
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Complaint Intake #23844-C
#24114-C

Bonnie Smith, Administrator
Bickford Cottage of Marion
1100 Linden Dr.
Marion, IA 52302-7714

Date of Investigation:

June 29 & 30, 2009

Monitor(s):

Michael Streepy RN
Victoria Clingan RN

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 revisit 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 of Marion on June 29 & 30, 2009. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	22
Current number of tenants with cognitive disorder:	9
Total Population of GPP:	31

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	7
Total Census of ALP:	7

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Program History – There have been no substantiated Regulatory Insufficiencies this certification period.

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

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

Complaint Allegation: Complaint #24114-C alleges the program did not develop service plans appropriate for tenants #1, #2, #4 and #8. The complaint also alleges the service plan updates are developed by the licensed practical nurse (LPN) and signed by the registered nurse coordinator (RNC) when she returns to the program.

Monitoring Observation: A review of records for eight tenants revealed the program had developed appropriate service plans for each of the individual tenants.

Tenant #1, a 92 year old, was admitted to the program on 5-20-09 with diagnoses including: Anemia, Atrial/Ventricular Block, Cardiomegaly, Dementia, Diabetes and Gastroenteritis. The tenant received a score of three on the Global Deterioration Scale (GDS), indicating mild cognitive decline. A review of the tenant's record reveals the service plan to be appropriate for the individual tenant including diabetes management.

Tenant #2, a 94 year old, was admitted to the program 07-17-08 with diagnoses including: Chronic Obstructive Pulmonary Disease (COPD), Dementia, Depression, Gastroesophageal Reflux Disease (GERD), Macular Degeneration and Mental Status Changes. The tenant received a score of three on the GDS, indicating mild cognitive decline. The service plan of 05-28-09 indicates the tenant was able to ambulate in his/her room with a walker and staff was directed to assist when he/she is up, due to shortness of breath and unsteadiness.

Tenant #4, a 94 year old, was admitted to the program 11-21-06 with diagnoses including: Atrial Fibrillation, Anxiety Disorder, Aortic Stenosis, Congestive Heart Failure (CHF), Dementia, Depression, Dysphagia, GERD, Hypertension (HTN), Chronic Urinary Tract Infection (UTI), Hypothyroidism and Closed Fracture of the Neck of the Femur/Left Hip. The tenant received a score of four on the GDS, indicating moderate cognitive decline. Progress notes dated 03-02-09, indicate the tenant had returned from a stay in a skilled facility and was a one person transfer and had hospice services. The service plan was consistent with the tenant's needs.

Tenant #8, an 88 year old, was admitted to the program on 2-10-09 with diagnoses including: COPD, Dementia, HTN, Hyperlipidemia and GERD. The tenant received a score of five on the GDS, indicating moderately severe cognitive decline. A service plan dated 06-19-09 appropriately addressed behavior and toileting issues for the tenant.

All of the service plans were appropriately signed, including by the registered nurse (RN).

- Regulatory Insufficiency: None noted.

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: Complaint #23844-C and #24114-C alleges Tenants #1, #2, #3, #4 and #8 are inappropriate for level of care in the assisted living program. Complaint #24114-C alleges Tenants #6, #7 and #8 have incontinence issues that may make the tenants inappropriate for the assisted living program level of care.

Monitoring Observation: Tenant #1, alleged to be wheelchair bound, was observed to be ambulatory in his/her apartment with a cane or wheeled walker and traveled the distance to the dining room in his/her wheelchair. The functional assessment of 06-11-09 indicates the tenant is to use a wheeled walker and requires standby assist with transfers and the walker when feeling weak.

Tenant #2 is alleged to require a three person assist for transfers and staff have been directed to call the fire department if he/she falls and assistance is needed to get him/her up. Review of the tenant's record revealed the functional assessment and service plan of 05-28-09 indicates the tenant ambulates in his/her room with a walker and staff are directed to assist him/her when he/she is up due to shortness of breath and unsteadiness. The tenant's record had nurse's notes dated 05-31-09, indicating the tenant had been found on the floor and required 3 staff to assist the tenant to the standing position. The tenant was transferred to a hospice house on 05-31-09.

Tenant #3, an 85 year old, was admitted to the program on 12-20-06 with diagnoses including: Cerebrovascular Accident (CVA), Degenerative Arthritis, Dementia, Depression, Pain, Pancreatic Lesion and Transient Ischemic Attack (TIA). The tenant received a score of six on the GDS, indicating severe cognitive decline. The tenant is alleged to require a two person assist for transfers and is not able to walk. A review of the tenant's record revealed an evaluation dated 05-20-09 indicating that on the return from skilled care the tenant did not require the assistance of two people for transfers. The tenant has a hip immobilizer and nurse's notes of 06-25-09 indicate the tenant had intermittent need of assistance of two for transfers and on 06-28-09, it was noted the tenant had required assistance of two during the entire weekend. On 06-29-09 the need for a routine two person assistance with transfers was noted and a waiver of occupancy and retention criteria was applied for with the Department of Inspections and Appeals.

Tenant #4 is alleged to have been readmitted to the program from a skilled facility and was unable to walk. A review of the tenant's record revealed the tenant had returned from skilled care on 03-02-09 and was assessed as a one person pivot transfer. The functional assessment dated 04-02-09 indicates the tenant is a one person transfer or may use two persons for safety, if the tenant is feeling weak, and the tenant is to use a wheelchair for mobility. The tenant was a hospice tenant and nurse's notes dated 04-06-09 indicated the tenant had expired.

Tenant #6, an 89 year old, was admitted to the program with diagnoses including: CHF, Dementia, HTN and Hypoxia. The tenant received a score of five on the GDS, indicating moderately severe cognitive deterioration. A review of the tenant's record revealed the functional assessment of 06-08-09 indicates the tenant is incontinent of bowel at times, the service plan dated 06-08-09 addresses the need for staff assistance with toileting needs.

Tenant #7, an 86 year old, was admitted to the program on 06-01-09 with diagnoses including: Dementia, Anxiety and a Fall Risk. The tenant received a score of five on the

GDS, indicating moderately severe cognitive decline. A review of the tenant's record reveals the functional assessment of 06-26-09 indicates the tenant is independent with toileting but is occasionally incontinent. The need for staff assistance with toileting during periods of unsteadiness or dizziness is addressed on the service plan of 06-20-09; the plan indicates the tenant may become incontinent during sycopal episodes.

Tenant #8 is alleged to have behaviors including having defecated in his/her refrigerator and exit seeking behaviors. A review of the tenant's record and an interview with program staff revealed no documentation of exit seeking behavior. A review of the tenant's progress notes dated 04-24-09 revealed staff had found the tenant's refrigerator open with urine and feces present inside the refrigerator. The progress notes of 04-28-09 indicate the tenant was found in the hall, inappropriately dressed. The progress notes of 05-07-09 indicate the tenant was taken for an inpatient psychological examination and was returned on 05-19-09 and readmitted to the memory unit. A review of the tenant's service plan dated 06-19-09 reveals both behaviors and toileting needs to be addressed.

- Regulatory Insufficiency: None noted.

C. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Complaint Allegation: Complaint 24114-C alleges there was no RN in the building the third week of December and the first two weeks in January of 2009.

Monitoring Observation: An interview with program staff person #5, an LPN, on 06-29-09 revealed the program had registered nurse coverage during that period. Interviews with the Program Nurse and Administrator revealed the program had registered nurse coverage during that period.

Complaint Allegation: Complaint 23844-C alleges Tenant #1 has diabetes and the program has no guidelines or medications for management of abnormal blood sugars.

Monitoring Observation: A review of the Service Plan dated 06-11-09, addresses the management of the tenant's diabetes, including, sliding scale insulin which was designated on the tenant's medication administration record (MAR). The tenant's insulin is drawn up by the Registered Nurse Coordinator (RNC) and the tenant administers the insulin to him/her self.

Complaint Allegation: Complaint #23844-C and #24114-C allege staff had to call the local fire department for Tenant #2 when the tenant fell.

Monitoring Observation: An interview with Staff #1, #2, #3 and #4 revealed that no one had called the fire department for assistance to help get the tenant up, following falls. An interview with the nurse on 06-29-09 revealed the staff are told they may summon the fire department if the staff feel a tenant cannot be safely assisted after a fall. The nurse stated she was not aware of any instances of the fire department being called for that purpose.

Complaint Allegation: Complaint #23844-C alleges Tenant #3 had both a hip brace and pivot disc that staff are not familiar with and are not using.

Monitoring Observation: Tenant #3 had an evaluation dated 05-20-09 indicating upon return from skilled care the tenant required the assistance of one for transfers. The tenant has a hip immobilizer and the nurse's notes of 06-25-09 indicate the tenant had intermittent need for assistance with a pivot disc. Interviews with Staff #1, #2, #3 and #4 revealed the staff were aware of the pivot disc and were using it. The tenant has a hip immobilizer that is addressed on the tenant's service plan and is removed for skin care. An interview with Staff #5, an LPN, on 06-29-09, revealed management of the hip immobilizer is provided by the hospice staff.

Complaint Allegation: Complaint 24114-C alleges Tenant #7 has fainting spells and the program has no protocol to address the problem.

Monitoring Observation: Tenant #7 had progress notes from 06-03-09 through 06-18-09 with noted sycopal episodes. A review of the tenant's service plan dated 06-26-09 revealed the service plan addressed the episodes and directed staff with appropriate interventions.

- Regulatory Insufficiency: None Noted.

D. Medications – Program has a comprehensive written medication policy that allows tenant self-administration, but accommodates the need for tenant medication assistance via nurse delegation. The medication assistance is appropriately supervised and administered. Medications are appropriately stored. [231C.16A]

Complaint Allegation: Complaint #24114-C alleges Tenants #1 and #5 are not able to self inject insulin.

Monitoring Observation: Tenant #1's file had documentation in the service plan dated 06-11-09 addressing the tenant's diabetes and stating that staff will draw up the tenant's medication and the tenant will self administer it. An interview with the tenant confirms the plan is implemented.

Tenant #5, an 82 year old, was admitted to the program on 09-19-06 with diagnoses including: Atherosclerotic Heart Disease, CVA, Dementia, Diabetes, HTN, Peripheral Vascular Disease (PVD) and Osteoporosis. The tenant scored a five on the GDS, indicating moderately severe cognitive decline. The tenant's service plan and assessments of 06-18-09 indicate the tenant is dependent for medication administration and the diabetes medication management is coordinated with the hospice nurse.

- Regulatory Insufficiency: None noted.

E. Other – The provisions of this section address the program's noncompliance with other applicable statutory and administrative rule requirements.

Complaint Allegation: Complaint #24114-C alleges Tenant #6 had an episode of fecal incontinence in the whirlpool.

Monitoring Observation: An interview with Staff #4 on 06-30-09 revealed that staff could recall only one episode of a tenant being incontinent of bowel in the whirlpool but stated he/she could not recall who the tenant was. Staff stated protocol was followed in regard to sanitizing the whirlpool then and between each tenant. The staff could explain the procedure in accordance with the protocol. Observation of the whirlpool room revealed the posted procedure and the sanitizing agents in the whirlpool cleaning cabinet.

- Regulatory Insufficiency: None noted.

Dated this 28th day of July, 2009.