IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

April 1, 2010

Incident #26491-I

Kim Schaffer, Director
Bickford Cottage
1150 13th Ave N
Clinton, IA 52732-3402

RE: Final Incident Investigation Report, Bickford Cottage, Clinton, IA

Dear Ms. Schaffer:

Enclosed is the **Final Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2009) and Iowa Administrative Code, chapters 481 – 67 and 69. **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 Incident Investigation Report

Assisted Living Program: **Incident Intake #: 26491-I**

Kim Schaffer, Director
Bickford Cottage
1150 13th Ave N
Clinton, IA 52732-3402

Date of Incident Investigation:

March 23, 2010

Monitor(s):

Stephanie Cummins, 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. IAC r. 481-67.10(5). 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 an Incident 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 481 IAC - chapter 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 or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Bickford Cottage on March 23, 2010. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition but may have tenants without cognitive disorder.

Current number of tenants in a DSP that serves fewer than 55 tenants and has 5 or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS) :	8
Current number of tenants without cognitive disorder:	27
Total Population:	35

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

Program History – The recertification monitoring visit for this certification period resulted in substantiated Regulatory Insufficiencies in the areas of: Transportation and Record Checks.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

A. Other

Incident Allegation: The program reported that on 11-27-09 a tenant was missing $200.00. This occurred in approximately a three hour timeframe.

Monitoring Observation: Tenant #1, 92 years old, was admitted on 9-4-09 and diagnoses include: Cerebrovascular Accident (CVA) and Hypertension (HTN). The tenant was staged at a two on the Global Deterioration Scale (GDS), which indicated very mild cognitive decline

According to the Incident Summary, Tenant #1's family reported to staff that the tenant was missing $200.00. The tenant and the family member both reported the tenant had cash in an envelope at 1:00 p.m. and then went shopping, leaving the envelope in the tenant's room. When he/she returned at approximately 3:45 p.m. the money was gone. The Director notified the Department and the local police. The police told the Director that since the tenant did not want to make a report, the Director could not make a report on the tenant's behalf. Staff statements were obtained for staff working at the time of the incident and staff were interviewed. The program did not identify a perpetrator.

The tenant was interviewed. The tenant stated he/she had an envelope either laying on the counter or in the drawer of the nightstand. The money was in an envelope and when he/she went to get it, the money was gone. At the time of the alleged theft, the tenant stated he/she never used to lock the door. The tenant now locks the door. The tenant stated he/she did not know who took the money. The tenant stated he/she felt safe at the program.

The tenant's family member was interviewed. She stated when the tenant returned he/she went to get the money and it was gone. Before the tenant left he/she had put the $200.00 in the drawer. The tenant did not have any other items missing and at the time of the incident did not lock his/her door. The family member stated the tenant did lock the door now and she did not have any idea who would have taken the money. The family member stated the program was great and the people were really nice.

Staff #1, #2, #3 and #4 were interviewed and also provided written statements regarding the missing money. These staff worked at the time the money went missing. A perpetrator could not be identified.

According to the tenant's file audit, staff interviews, an interview with the Director and an interview with the tenant and the tenant's family member, a perpetrator could not be identified regarding the missing money.

- Regulatory Insufficiency: None noted.

Dated this 1st day of April, 2010.