IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Incident Intake: #28953-I

August 4, 2010

Bonnie Smith, Director
Bickford Cottage Assisted Living
1100 Linden Drive
Marion, IA 52302-7714

RE: Final Incident Investigation Report – Bickford Cottage Assisted Living, Marion, IA

Dear Ms. Smith:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of July 19, 2010, 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 515-281-5003.

Sincerely,

Connie Schaffer

Connie Schaffer
Certification Coordinator - Central/Eastern Iowa
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Incident Intake #: 28953-I**

Bonnie Smith, Director
Bickford Cottage Assisted Living
1100 Linden Drive
Marion, IA 52302-7714

Date of Incident Investigation:

July 19, 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 Assisted Living on July 19, 2010. In preparing this report, the following information was considered:

A. Other

Incident Allegation: It was reported a tenant was found on the floor and later complained of a headache and became unresponsive. The tenant was transported to the Emergency Room (ER). It was reported the tenant had a subdural hematoma of the left temple.

- Monitoring Observation: Tenant #1, a 79 year old, was admitted on 12-22-09 and diagnoses include: Dementia Alzheimer's and Depressive Disorder. The tenant was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. The tenant resided in the dementia unit. The tenant died on 5-24-10.

  According to an Incident Report (and addendums) on 5-20-10 at 2:15 p.m. staff heard a loud noise and found the tenant sitting on the floor in the living room. Vitals were taken and the nurse was notified. The tenant was assisted to the couch and staff sat with the tenant. The staff reported she was in the kitchen at the refrigerator with another tenant, when she heard a loud "thump." The tenant was scooting on his/her buttocks and asked the staff to help; three staff assisted the tenant to stand. The tenant sat on the couch with staff and then was up and down from chair to chair accompanied by staff for one hour.

  According to Progress Notes dated 5-20-10, at 2:20 p.m. staff found the tenant sitting on the living room floor and the tenant stated "get me up." At 4:30 p.m. the tenant walked to use the bathroom, sat on the toilet and then became unresponsive after sitting on the toilet. The tenant was sent by ambulance to the hospital. The hospital called and reported the tenant had a subdural hemorrhage. According to Progress Notes dated 5-21-10, the surgeon had noted the tenant had significant brain injury prior to the fall due to stroke and Alzheimer's Dementia, so surgical intervention was not a good option. The doctor also noted, due to significant atrophy of the brain there was a lot of space for the blood clot to occupy before it became life threatening. The tenant died at the hospital on 5-24-10.

  According to Incident Reports the tenant fell or was found on the floor on 4-9-10, 4-10-10, 4-11-10, 4-27-10, 4-28-10, 5-10-10 and on 5-20-10. The other incidents on 4-9-10 to 5-10-10 did not result any significant injuries. An incident report was found for all of the falls.

  The tenant's service plan updated on 3-15-10 provided a list of interventions for fall preventions for pacing. Cognitive, health and functional evaluations were completed on 3-15-10. The tenant's service plan was last updated on 3-15-10. The evaluations and service plan were updated appropriately. Nurse review was completed appropriately.

  The tenant's doctor ordered Risperidone tablet 0.5 mg every am on 5-6-10. The tenant's doctor was notified on 5-10-10 increased edema. The tenant was seen by the doctor on 5-19-10 for increased aggressive behavior, edema, urinary retention and complaints of left hand. The doctor ordered to maintain Risperadol at current dose and ordered Lorazepam, Doxazosin Mesylate and Ibuprofen. Medication

Administration Records for May 2010 indicated medications were administered per doctor orders.

Staff #1, Staff #2 and the nurse indicated there were sufficient staff to meet the needs of the tenants.

The nurse stated she was doing an assessment and staff called and stated the tenant had fallen. At approximately 2:00 p.m. to 2:15 p.m. the tenant was seated in a chair, staff went to the kitchen (in the dementia unit) and staff heard a thump. Staff immediately responded and saw the tenant scooting. The tenant did not have any bruising or swelling. The nurse stated there was no external evidence of injury. Staff checked vitals and observed the tenant. The tenant was up and wanted to sit up on the chair. At approximately 3:00 p.m. to 4:00 p.m. the tenant was assisted to the bathroom and on the way to the bathroom complained of his/her head hurting, while in the bathroom the tenant had a low level response. The nurse indicated from the first fall or found on the floor until the complaints of headache there was nothing unusual. The tenant rested in the chair, responded verbally and did not have any increased agitation. From the time the tenant fell and was sent to the hospital, staff remained with the tenant.

The program reported the incident to the Department appropriately.

- Regulatory Insufficiency: None noted.

Dated this 4th day of August, 2010.