IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Complaint Intake: 29630-C
Incident Intake: 29629-I

September 29, 2010

Ms. Patrice McNichol
Bickford Cottage
3500 Lower West Branch Road
Iowa City, IA 52240-4106

RE: Final Complaint and Incident Investigation Report, Bickford Cottage, Iowa City, Iowa

Dear Ms. McNichol:

Enclosed is the **Final Complaint and 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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint and Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified regulatory insufficiencies of Staffing and Tenant Rights, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Program Coordinator - Central

Adult Services Bureau

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

Assisted Living Program:

Patricia McNichol, Director
Bickford Cottage
3500 Lower W Branch Road
Iowa City, IA 52240-4106

Complaint Intake: #29630-C
Incident Intake: #29629-I

Date of Investigation:

August 3, 4 & 5, 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 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 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:

A complaint investigation and on-site visit was conducted at Bickford Cottage on August 3, 4 & 5, 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 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS:	8
Current number of tenants without cognitive disorder:	24
Total Population:	32

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

Program History – There have been substantiated Regulatory Insufficiencies this certification period in the areas of: Evaluation of Tenants, Tenant Documents, Service Plans, Medications, Staffing, Nurse Review, Dementia – Specific Education, Record Checks and Other (not notifying DIA within 24 hours of an incident resulting in serious injury or death).

The February 16, 17 and 18, 2010 Incident and Complaint Investigation resulted in a civil penalty of $1,000.00 and Regulatory Insufficiencies in the areas of: Medications, Staffing, Dementia – Specific Education and Record Checks.

The October 6 and 7, 2009 Incident Investigation resulted in a civil penalty of $1,000.00 and a Regulatory Insufficiency in the area of Other (not notifying DIA within 24 hours of an incident resulting in serious injury or death).

The August 5 and 6, 2009 Complaint Investigation resulted in a civil penalty of $500.00 and Regulatory Insufficiencies in the areas of: Evaluation of Tenants, Tenant Documents, Service Plans, Staffing and Other (not notifying DIA within 24 hours of an incident resulting in serious injury or death).

The May 12, 13 & 17, 2010 Complaint Investigation resulted in substantiated Regulatory Insufficiencies in the areas of: Nurse Review and Staffing.

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

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

A. Tenant Documents

Complaint Allegation #29630-C: It was alleged tenant records were altered.

- Monitoring Observation: The monitor reviewed six tenant files and did not observe any records had been altered. The program provided all documents requested. Staff #1, #3, #4, #5 and the Director stated there were no issues with records altered or falsified.

- Regulatory Insufficiency: None noted.

B. Medications

Complaint Allegation #29630-C: It was alleged the medication room door was open at times.

- Monitoring Observation: The medication room was observed on 8-3-10, 8-4-10 and 8-5-10 at various times. The monitor observed the medication room door was consistently locked or if unlocked was attended by staff. Staff #1, #3, #4, #5, #6 and the Director stated the medication room was locked or attended if unlocked.

- Regulatory Insufficiency: None noted.

C. Nurse Review

Complaint Allegation#29630-C: It was alleged a tenant had a change in condition and the tenant was not assessed as needed.

- Monitoring Observation: Six tenant files were reviewed including tenants that had been hospitalized. Tenant #2 and #3 were hospitalized in June and July 2010.

  Tenant #2, a 97 year old, was admitted on 9-21-09 and diagnoses include: Dementia, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Atrial Fibrillation and Chronic Obstructive Pulmonary Disease (COPD). The tenant was discharged on 6-14-10. According to Progress Notes on 5-26-10, the tenant was not feeling well, his/her blood pressure was low, and the tenant was pale and lethargic. Nurse review was completed appropriately. On 6-13-10, notes indicated the tenant was taken to the Emergency Room (ER) per tenant's request. The tenant complained of pain in the left inner thigh and inability to bear weight on left. Staff #3, stated the pain started that morning and the tenant was taken to the ER and did not return to the program. Nurse review was completed appropriately.

  Tenant #3, an 89 year old, was admitted on 2-25-06 and diagnoses include: Actinic Keratosis, Anxiety, CHF, Constipation, Cough, Dementia, Diarrhea, Eczema, Hemorrhoids, Hypertension (HTN), Hyperlipidemia and Pain. The tenant was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The tenant was discharged on 7-4-10. According to Progress Notes dated 6-25-10 an order was received for a Urinalysis (UA) and Culture. Notes of 6-27-10 at 8:30 a.m. indicated vitals were obtained. The tenant's skin was pale and cool to

touch. Respirations were fast and labored and when a deep breath was taken the rate dropped. Tylenol was given for temperature, according to the notes. The tenant denied pain and moved all extremities. The tenant was responsive without any complaints. Fluids were encouraged and the tenant was seated in the recliner, according to notes. Progress Notes dated 6-27-10 at 9:20 a.m. indicated the tenant's temperature was 98.9 and family was with the tenant. The tenant was eating breakfast and took medications without incident. Notes indicated the tenant was transported to the ER. The tenant was admitted to hospital with diagnoses of CHF, Urinary Tract Infection (UTI) and Pneumonia, according to the notes. Staff #2 stated that morning the tenant was breathing heavily and had a high temperature. Staff #1 (an RN) was notified. Vitals were taken and third shift communicated information to oncoming staff. Staff #5 stated she worked that morning and third shift told her the tenant had a temperature. Staff #5 took the tenant breakfast in his/her room and the tenant ate very little. At approximately 8:30 a.m., the tenant's family reported the tenant had difficulty breathing. Staff #1 was in the building and checked vitals and listened to the tenant's lungs. Staff #5 worked the previous day and did not observe anything different with the tenant. Staff #1, the backup RN, worked that morning until approximately 12:00 p.m. and administered medications. Staff #1 stated staff told her the tenant was not himself/herself. She took vitals. The tenant was checked again within one hour and a staff got the tenant dressed and in the recliner. The tenant received a tray for the breakfast meal. The tenant's family reported the tenant was not improving and Staff #1 took vitals. Staff #1 left before the tenant went to the ER. The Director indicated when she arrived she was informed the tenant had a fever and was given Tylenol. The Director stated Staff #1 had taken vitals and listened to the tenant's lungs and did not feel it warranted sending the tenant out; however, the tenant's family wanted to and Staff #1 encouraged the family to take the tenant if they wanted. The Director stated Staff #1, the backup RN, was involved and was a competent nurse. The Director stated once family told staff the tenant was going to the ER the tenant was looked after and monitored according to what was going on with the tenant. Once it was known the tenant was going out, staff monitored and kept the tenant comfortable. The Director stated she had spent time with the tenant the previous day and there were no differences with the tenant at that time. Nurse review was completed appropriately.

- Regulatory Insufficiency: None noted.

D. Staffing

Incident Allegation #29630-I: The program reported Tenant #3 walked out of the building and staff were alerted and responded. It was reported the tenant was unharmed and willingly returned to the building.

- Monitoring Observation: Tenant #1, a 93 year old, was admitted on 3-28-09 and diagnoses include: Atrial Fibrillation, Benign Prostate Hypertrophy (BPH), Falling Episodes, HTN, Hypercholesterolmia, Transient Ischemic Attack (TIA) and Frontal Intraparenchymal Hemorrhage (IPH). The tenant was staged at a five on the GDS, which indicated moderately severe cognitive impairment. According to the tenant's service plan the tenant had a pad alarm under him/her at all times. The tenant also had a wandering detection watch that was worn at all times.

According to an Incident Report, a staff's pager went off and indicated the door was open. Staff responded promptly and Tenant #1 was found outside and confused. The tenant was checked and redirected back to the building, according to the Incident Report.

The program reported the elopement to the Department appropriately.

According to Progress Notes, the tenant dressed himself/herself and exited the building. Staff were alerted by the pagers and found the tenant outside sitting on an air condition unit. The notes indicated the tenant was found outside within a minute. The tenant willingly came back into the building

Staff #2 worked at the time of Tenant #1's elopement. According to Staff #2 at approximately 4:30 a.m. to 5:30 a.m. she heard an alarm that alerted staff the door was opened. Staff found the tenant sitting on the heating unit. The tenant's vitals were taken and Staff #1, the on call nurse, was notified. Staff #2 stated the pad alarm and wandering detection watch did not alert staff at the time of the elopement.

On 6-28-10 the door was opened at 5:38:59 and was reset at 5:39:39, according to records shown to the monitor on the program's computer system. According to the tenant's service plan the tenant had a wandering detection watch and a pad alarm. The computer system did not indicate the tenant's wandering detection watch and pad alarm functioned around the time of the elopement. The system indicated on 6-25-10 to stop monitoring and on 7-4-10 to start monitoring. During this time, the tenant eloped from the building on 6-28-10.

- Regulatory Insufficiency: Each tenant shall have access to a 24-hour personal emergency response system that automatically identifies the tenant in distress and can be activated by one touch. (IAC r.481-69.29(1))

Complaint Allegation #29630-C: It was alleged the Director's nursing license has a "red flag."

- Monitoring Observation: Copies of nursing licenses were obtained for the Director, the nurse and Staff #1, the backup RN. Copies of licenses indicated all three nursing licenses were current. This allegation was addressed in the May 2010 onsite and a regulatory insufficiency was not given at that time.

- Regulatory Insufficiency: None noted.

E. Tenant Rights

During the course of the investigation, the following information was obtained.

- Monitoring Observation: According to an Incident Report dated 7-26-10, Tenant #4 claimed to "fear" a staff member. The tenant identified Staff #9 and expressed fear of repercussions of his/her statement. One tenant was interviewed and stated two staff were rough, one refused to get to get the tenant water on occasion, used foul language and the tenant preferred not to provide names. The tenant said the staff would blame

him/her for things and for staff getting hurt. The tenant stated there was no harm; however, the staff were rough.

Staff #2 stated Staff #9 was not empathetic or patient. Staff #2 stated Staff #9 took Tenant #5's walker and pulled it to get him/her to go faster. Tenant #5 got into bed knees first and buttocks in the air and Staff #9 pushed the tenant to make the tenant go faster causing the tenant to bump his/her head. However, the tenant did not sustain an injury. Staff #2 stated Staff #9 shook Tenant #4's walker and used foul language in the tenants' presence.

Staff #7 stated, a tenant told her, Staff #9 did not get the tenant water when requested and told the tenant walk faster. Staff #7 stated it was not what the tenants wanted, but it was what Staff #9 wanted.

Staff #8 stated she trained with Staff #9 and she did not like the way Staff #9 spoke to the tenants. She stated Staff #9 pushed Tenant #4's walker and tried to get the tenant to walk faster. She stated Staff #9 was not very gentle with cares. She stated Tenant #5 climbed into bed and staff would redirect the tenant. Staff #9 pushed the tenant to get him/her to lie down correctly. According to staff and tenant interviews, tenant rights were not upheld.

- Regulatory Insufficiency: All tenants have the following rights: To be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481 - 67.3(1))

F. Other

Complaint Allegation #29630-C: It was alleged communication book records were destroyed after two days.

- Monitoring Observation: The monitor requested communication book records at the entrance meeting. The records were provided to the monitor in a prompt manner. The Director provided a statement that indicated the communication book was to have only three days of communication logs and the first shift LPN was responsible for removing the logs after three days. There is not a rule requirement to have or maintain communication logs.

- Regulatory Insufficiency: None noted.

Dated this 30th day of August, 2010.