IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Complaint: #299017, C #29093-C
Incident: #29091

September 14, 2010

Peggy O'Neill, Administrator
Bickford Cottage of Urbandale
5915 Sutton Place Drive
Urbandale, IA 50322-1877

RE: Final Complaint and Incident Investigation Report

Dear Ms. O'Neill:

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 in the areas of: Evaluation of Tenant, Criteria of Exclusion of Tenants, Nurse Review, Service Plan and Other, 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

Rose Boccella
Program Coordinator - Central
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Peggy O'Neill, Administrator
Bickford Cottage of Urbandale
5915 Sutton Place Drive
Urbandale, IA 50322-1877

Complaint Intake: #29017-C
29093-C
Incident Intake: #29094-I

Date of Investigation:

June 8, 9 and 14, 2010

Monitor(s):

Joyce Kix, 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. 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 on-site visit was conducted at Bickford Cottage of Urbandale on June 8, 9 and 14, 2010. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that does include a Dementia Specific unit, but may include have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	19
Current number of tenants with cognitive disorder:	16
Total Population of GPP:	35

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

Total Population of DSP:	11

Total Census of ALP: 46

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

Program History – The program has had substantiated Regulatory Insufficiencies in the areas of Record Checks, Structural Requirements and Food Service during this recertification period.

The complaint history during this certification period includes the recertification monitoring evaluation report and revisit of #15017-C on July 28 & 29, 2008, with Regulatory Insufficiency in the area of Record Checks, which resulted in a $500.00 fine.

The complaint investigation of #25076-C on September 22, 2009, with Regulatory Insufficiency in the area of Structural Requirements, which resulted in a $500.00 fine.

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

A. Evaluation of Tenant

Incident Allegation #29094-I: It was reported on 5-28-10 by the program that Tenant #1 sustained an injury of unknown origin which was noted 5-18-10 and not reassessed until 5-20-10 when the tenant began guarding his/her arm. The family decided to take the tenant to the hospital.

Monitoring Observation: Tenant #3, a 68 year old, was admitted 6-27-06 with diagnoses of: Diabetes, Dementia, Bipolar Affective, Hypercholesterolem and Hypothyroidism. The cognitive assessment completed 2-15-10 and 5-19-10 scored the tenant with a Global Deterioration Scale (GDS) of 6, which indicated severe cognitive decline. The service plan of 2-15-10 indicated the tenant's speech was very difficult to determine mentation due to the lack of speech. The service plan of 5-19-10 documented the tenant was independent with ambulation. According to interview with Staff #1, a certified medication aide (CMA), she had been called during the morning of 5-18-10 to look at a bruise on the tenant's right arm. Staff #1 assessed the bruise to be about the size of a fist. Staff #1 identified no other injuries and reported the bruise to the registered nurse (RN). Staff #1 stated prior to the new nurse she would have been responsible to write an incident report, but the new nurse wants to assess the situation first. On the morning of 5-19-10, Staff #1 was again called to the tenant's room and visualized the bruise to have increased in size; the arm was now swollen with some restriction of movement noted. The tenant was reported to be holding his/her arm close to his/her body. Staff #1 again reported this information to the RN and was told the RN would fax the doctor. Staff #2 reported identification of the bruise on 5-18-10 at 2:30 p.m. Staff #2, assumed the tenant had fallen and injured his/her arm and upon discussion with other staff learned the RN was aware of the bruise. On 5-20-10 Staff #2 reported calling Tenant #3's legal representative to sign a new service plan. At this time Staff #2 advised the family member of the injury to Tenant #3. The tenant's family member visited the tenant on 5-21-10 and decided the tenant's injury needed to be examined; the tenant was then transferred to the hospital and admitted, with a spiral fracture of the humerus. The tenant was discharged from the hospital to a nursling facility.

The clinical record contains an entry by the RN in the Progress Notes dated 5-18-10 at 10:30 a.m. identifying a red and dark blue bruise 10 by 20 centimeters on the right deltoid of unknown etiology. The nursing assessment completed by the RN 5-19-10 identifies the skin as dry with no other notations. A progress note dated 5-20-10 at 11:55 a.m. documented a fax was sent to the physician requesting a portable x-ray of the arm. Another progress note dated 5-21-10 at 10:50 a.m. documented the fax was sent again because the bruise was larger and swelling and the tenant was more guarded with his/her arm. The progress note of 5-21-10 at 6:30 p.m. documented that family was advised of the injury during a visit to the program. The clinical record lacked evaluations by the RN of the injury after 5-18-10 to determine if any changes to services were needed.

The Incident report completed by the RN and dated 5-18-10 documented the physician and family was not notified of the injury. The bottom portion of the form for further action was left blank.

According to the medication administration record, the tenant did not receive any medication for pain relief from 5-18 to 5-21-10.

The tenant's clinical record lacks documentation after the point when the family member was told of the injury on 5-21-10. The documentation of the disposition of the tenant to the hospital with admission was not found in the clinical record.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481 – 69.22(2))

B. Criteria for Exclusion of Tenants

Complaint Allegation #29093-C: It was alleged the program retained tenants who exceeded the level or care.

Monitoring Observation: Tenant #1, a 79 year old, was admitted 6-7-09 with diagnoses of: Senile Dementia, Hypertension (HTN), Hypovolemia and Cerebral Vascular Accident. The clinical record indicated the tenant was admitted to Hospice on 1-31-10. The GDS dated 5-6-10 documented a score of 6, indicating severe cognitive decline. During observation on 6-9-10 at 8:00 a.m., the tenant was seated in a wheelchair at the dining room table, with braces on left and right hands and with thickened liquids placed in front of him/her. The tenant made no attempt to eat and at 8:10 staff sat down and fed the tenant, with no participation by the tenant. During observation on 6-14-10 at 11:15 p.m. the tenant was transferred with the assist of two staff from a recliner to a wheelchair. At 12:17 p.m. staff fed the tenant, who made no attempt to eat. The service plan of 5-6-10 directed staff to open packets, cut food and provide hand over hand assist to eat at times. The service plan noted the tenant occasionally requires the assist of two if weak or tired for transfers.

Staff #1 stated Tenant #1 required a two person transfer and required 100% of cares provided by staff.

Staff #4 stated there were three tenants who required the assistance of two staff for safe transfer and indicated Tenant #1 was one of them.

Tenant #2, an 86 year old, was admitted 8-9-04 with diagnoses of: Alzheimer's Dementia, HTN, Degenerative Joint Disease, and History of Breast Cancer. The clinical record documented the tenant was admitted to Hospice on 3-23-09. The GDS dated 4-9-10 documented a score of 6, indicating severe cognitive decline. The service plan of 4-9-10 directed staff to provide verbal prompts and hands on hand assist with oral intake and transfer assist of two staff late in the day, when tired, or

when experiencing unresponsive episode. Observation on 6-9-10 at 8:00 a.m. revealed the tenant seated in a wheel chair at the dining room table with staff feeding the tenant, with no participation by the tenant. During observation on 6-14-10 at 10:00 a.m., two staff members applied a gait belt and transferred the tenant to a wheelchair from a recliner. The two staff members toileted the tenant, during which time the tenant attempted to sit before pivoting to the toilet, so the staff physically held the tenant up and pivoted him/her. At 12:15 p.m. the tenant was observed at the dining room table with a Hospice aide present and feeding the tenant.

Staff #5 stated Tenant #2 absolutely could not be safely transferred without two staff.

Staff #4 stated there were three tenants who required the assistance of two staff for safe transfer and indicated Tenant #2 was one of them.

Tenant #4, an 83 year old, was admitted on 2-9-06 with diagnoses of: Alzheimer's, Osteoporosis, Hypercholesterolem and Diabetes. The GDS dated 4-20-10 documented the tenant scored 6, which indicated severe cognitive decline. The service plan dated 4-20-10 directed staff to prepare the tenant's plate, with verbal cueing and some hand over hand assistance if tenant is tired or not motivated. During observation on 6-9-10 at 8:00 a.m. staff fed the tenant who was seated slumped in a wheelchair with a neck brace and did not participate.

Staff #4 stated there were three tenants who required the assistance of two staff for safe transfer, and indicated Tenant #4 was one of them.

Staff #3 stated Tenant #4 was a two person assist for transfer preferred for safety of the tenant, and further stated, Tenant #4 couldn't do anything anymore.

Staff #1 stated Tenant #4 required a two person transfer and required 100% of cares provided by staff.

Staff #5 stated their practice was to use two staff to transfer Tenant #4.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: a. Is bed-bound; or b. Requires routine, two-person assistance with standing, transfer or evacuation; or c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually aggressive or abusive, or displays unmanageable verbal abuse or aggression; or (2) Displays behavior that places another tenant at risk; or d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; or e. Is under the age of 18; or f. Requires more than part-time intermittent health related care; or g. Has unmanageable incontinence on a routine basis despite an individualized toileting program; or h. Is medically unstable; or i. Requires maximal assistance with activities of daily living. (IAC r. 481 - 69.23(1))

C. Medications

Complaint Allegation #29093-C: It was alleged tenants did not receive medications or blood sugar tests as ordered by the physician.

- Monitoring Observation: Two clinical records of tenants with Diabetes were reviewed. The clinical record for Tenant #3 contained a physician's order to discontinue blood sugar checks 5-21-09. The clinical record Medication Administration Record (MAR) for Tenant #4 contained evidence of blood sugar testing as ordered by the physician one time a month.

  Review of the MAR for the months of May and June revealed all medications were signed given as ordered.

- Regulatory Insufficiency: None noted.

D. Nurse Review

Complaint Allegation #29017-C: It was alleged the program did not assess an injury appropriately.

- Monitoring Observation: According to interview with Staff #1, CMA, had been called during the morning of 5-18-10 to look at a bruise on the tenant's right arm. Staff #1 assessed the bruise to be about the size of a fist. Staff #1 identified no other injuries and reported the bruise to the RN. On the morning of 5-19-10, Staff #1 was again called to the tenant's room and visualized the bruise to have increased in size; the arm was now swollen with some restriction of movement noted. The tenant was reported to be holding his/her arm close to his/her body. Staff #1 again reported this information to the RN and was told the RN would fax the doctor.

  The clinical record of Tenant #3 lacked documentation of nursing assessment and evaluation on 5-19-10, when the staff reported significant changes of the tenant's injury to the RN. Upon family request 5-21-10 the tenant was transferred to the hospital and admitted with a spiral fractured humerus.

- Regulatory Insufficiency: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

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

E. Service Plan

Monitoring Observation: During observation on 6-9-10 at 8:00 a.m., Tenant #1 was seated in a wheelchair at the dining room table with braces on left and right hands with thickened liquids placed in front of him/her. The tenant made no attempts to eat and at 8:10 staff sat down and fed the tenant. During observation on 6-14-10 at 11:15 p.m. the tenant was transferred with the assist of two staff from a recliner to a wheelchair. At 12:17 p.m. staff fed the tenant who made no attempt to reach for food or eat. The service plan of 5-6-10 directed staff to open packets, cut food and provide hand over hand assist to eat at times.

At 12:15 p.m. Tenant #2 was observed at the dining room table with a Hospice aide present and totally feeding him/her. The service plan of 4-9-10 directed staff to

provide verbal prompts and hands on hand assist with oral intake and transfer assist of two staff late in the day, when tired, or when experiencing unresponsive episode.

During observation on 6-9-10 at 8:00 a.m. staff fed Tenant #4 who was seated slumped in a wheelchair with a neck brace in place. The service plan dated 4-20-10 directed staff to prepare the tenant's plate with verbal cueing and some hand over hand assistance if tenant is tired or not motivated.

The service plans of Tenant's #1, #2 and #4 did not reflect the actual cares provided by staff.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481 - 69.26(1))

F. Other

Monitoring Observation: Tenant #1 sustained an injury, which was noted by the program on 5-18-10. The tenant was transferred to the hospital on 5-21-10 and noted to have a spiral fracture of the humerus. The tenant was admitted to the hospital. Staff #2 reported speaking to hospital staff two times on 5-21-10. The program did not report the injury of unknown etiology to the department until 5-28-10.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury. A. "Major injury" shall be defined as any injury which: (1) results in death; or (2) Requires admission to a higher level of treatment. Other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician's extender who determines, in writing on a form designated by the department, that an injury is a "major injury" based on the circumstances of the accident, the previous functional ability of the tenant, and the tenant's prognosis. (IAC r. 481 - 67.4(1))

Dated this 19th day of July, 2010.