IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 33276-I

April 15, 2011

Nicole Valladolid, Administrator
Bickford Cottage I
4020 Indian Hills Drive
Sioux City, IA 51108

RE: Final Incident Investigation Report – Bickford Cottage I, Sioux City, IA

Dear Ms. Valladolid:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of April 7, 2011, 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 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Incident Intake #: 33276-I

Nicole Valladolid, Administrator
Bickford Cottage I
4020 Indian Hills Drive
Sioux City, IA 51108

Date of Incident Investigation:

April 7, 2011

Monitor(s):

Hal L. Chase, RN BSN MPH

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 I on April 7, 2011. 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) :	7
Current number of tenants without cognitive disorder:	22
Total Population:	29

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

Program History – There were no substantiated Regulatory Insufficiencies found during this certification period.

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

A. Other

Incident Allegation: The program reported staff notified the program nurse an unknown amount of jewelry was missing from a tenant's apartment. Staff had cleaned and organized the tenant's apartment. Staff entered the tenant's apartment on 3-9-11 in search of another article and became aware the jewelry was missing from where staff had placed the jewelry. The program nurse reported all program staff had access to the tenant's apartment. The tenant, who had a cognitive impairment, could not confirm the missing jewelry. The tenant's legal representative was uncertain of the amount or type of jewelry missing. The tenant's legal representative chose not to notify local police.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1 a 99 year old, was admitted on 11-1-06 and had diagnoses of: Hypertension, Macular Degeneration, Aortic Stenosis and a history of a Fractured Hip. A cognitive evaluation was completed on 3-9-11, staged the tenant at four on the GDS, which indicated moderate cognitive impairment. The tenant was admitted to hospice on 1-21-11 with an admitting diagnosis of Clinical Decline. Progress notes of 11-13-10 revealed the tenant was admitted to the hospital for a right hip fracture. A nurse review of 1-14-11 revealed the tenant returned to the program and an outside provider would be providing assistance with activities of daily living (ADLs) from 8:00 a.m. – 6:00 p.m. daily, with program staff providing care when the outside provider was not available.

  An incident report of 3-10-11 revealed there was a "potential missing jewelry," discovered by staff on 3-9-11. Staff had been searching for a misplaced item and was not able to find some of the tenant's jewelry. Staff reported staff from the outside provider had cleaned the tenant's apartment on 3-5-11.

  Progress notes of 3-9-11 revealed Staff #1 reported the missing jewelry. The program nurse reported Staff #1 had organized clothing and incontinence products in the tenant's apartment to assist the outside provider staff in finding these items more readily. Staff #1 had placed the tenant's jewelry in smaller jewelry boxes and placed the jewelry boxes in a shoe box and placed the shoe box in the tenant's closet. Outside provider care staff had cleaned and arranged things in the tenant's apartment the weekend of 3-5-11. The program nurse found empty jewelry boxes in the tenant's shoe box.

  Staff #1 was interviewed and stated sometime before the tenant returned from the hospital, she went to the tenant's apartment and organized the tenant's belongings. When asked the date she organized the tenant's apartment, she stated she wasn't sure of the date, but may have done so the weekend of 1-22-11 or 2-5-11. She knew the tenant was to have an outside care provider to assist with ADLs. The tenant's belongings, including necklaces, ear rings and anything else of sentimental value had been misplaced in dresser drawers and in the tenant's closet. In order to safeguard the tenant's belongings, she placed the jewelry in a shoe box and placed the box in the tenant's closet, along with other boxes.

  The outside provider was contacted and documentation revealed services began 1-14-11 and concluded on 3-9-11. At least six staff provided cares during this period services were provided. Criminal background checks had been completed and each

had completed dependent adult abuse training. Documentation revealed no criminal backgrounds and no history of disciplinary actions had been imposed. Program staff schedules for January through March, 2011, revealed at least 12 staff had access to the tenant's apartment during this period.

- Regulatory Insufficiency: None noted.

Dated this 7th day of April, 2011.