IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 34491-I

July 1, 2011

Ms. Mary Keen, Director
Bickford Cottage
101 Newcastle Road
Marshalltown, IA 50158

RE: Final Incident Investigation Report – Bickford Cottage, Marshalltown, IA

Dear Ms. Keen:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of June 29, 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

LUCAS STATE OFFICE BUILDING, 321 EAST 12TH STREET, DES MOINES, IOWA 50319-0083

ADMINISTRATION
(515) 281-5457
FAX: (515) 242-6863

ADMINISTRATIVE HEARINGS
(515) 281-6468
FAX: (515) 281-4477

HEALTH FACILITIES
(515) 281-4115
FAX: (515) 242-5022

INVESTIGATIONS
(515) 281-5714
FAX: (515) 242-6507

Telephone Number for the Hearing Impaired: (515) 242-6515

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

Assisted Living Program: **Incident Intake #:** 34491-I

Mary Keen, Director
Bickford Cottage
101 Newcastle Rd.
Marshalltown, Iowa 50158

Date of Incident Investigation:

June 29, 2011

Monitor(s):

Maribeth Freland RN
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 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 Marshalltown on June 29, 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):	12
Current number of tenants without cognitive disorder:	26
Total Population:	38

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

Program History – There were substantiated Regulatory Insufficiencies found in the areas of: Food Service, Record Checks during this certification period.

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

A. Staffing

Incident Allegation: The program reported a tenant became sexually aggressive toward another tenant

- Monitoring Observation:

  The monitors reviewed incident reports, the clinical records of Tenants #1, #2, #3 and #4 and interviewed the program Director, Staff #1 and Staff #2 resulting in the following observations.

  Tenant #1, a 69 year old, was admitted 4-6-11 with diagnoses: Cerebral Vascular Accident with Right-sided Hemiparesis, Atrial Fibrillation, and Hypertension (HTN). Tenant #1 scored at a 3 on the Global Deterioration Scale (GDS) of 5-5-11, which indicated mild cognitive decline. An incident report, dated 5-31-11, documented another tenant, (Tenant #3), entered Tenant #1's room uninvited. Tenant #1 redirected Tenant #3 to the common dining room and reported the intrusion to administration without incident.

Tenant #2, an 87 year old, was admitted 4-16-2007 with diagnoses of: Parkinson's Disease, Osteoporosis, and Diverticulitis. Tenant #2 scored at a 6 on the GDS of 2-16-11, which indicated severe cognitive decline. The service plan, dated 2-16-11, documented Tenant #2 required staff member assistance for all activities of daily living. Observation on 6-29-11 revealed Tenant #2 was alert and responded appropriately to advocate for his/her needs. An incident report, dated 6-16-11, documented another tenant (Tenant #3) was found in Tenant #2's apartment engaged in nonconsensual sexual interaction. Staff members immediately separated Tenant #2 and Tenant #3, evaluating Tenant #2 for injuries and reported the incident to Tenant #2's family and physician.

Tenant #3, an 87 year old, was admitted on 6-30-09 with diagnoses of: Congestive Heart Failure and HTN. The tenant scored a 4 on the GDS of 5-31-11, which indicated moderate cognitive decline. The tenant's service plan, dated 6-3-11, indicated he/she required verbal reminders from staff members to take his/her medications daily. The service plan indicated he/she was independent with bathing, grooming, dressing, toileting and mobility.

In December 2010, Tenant #3 began experiencing verbal aggressiveness, visual hallucinations and paranoia. The program staff immediately contacted Tenant #3's durable power of attorney (DPOA) and physician, reporting the change in cognitive status. After examination, the physician diagnosed Tenant #3 with acute delirium, directing staff members to perform gentle reorientation when the behaviors occur. The physician also recommended a psychiatric evaluation however the DPOA for Tenant #3 refused the evaluation.

Tenant #3 continued to exhibit the same verbal aggressiveness toward staff members, visual hallucinations and paranoia from December 2010 through May 2011 without any aggressiveness or disruption to other program tenants.

In late May 2011, Tenant #3 began experiencing difficulty with sleeping, showing increased confusion and agitation during the night of 5-30-11. Tenant #3 wandered into Tenant #1's apartment on the morning of 5-31-11. Tenant #1, a cognitively intact tenant, guided Tenant #3 to the common dining room area. A staff member redirected Tenant #3 successfully without incident. The nurse contacted Tenant #3's durable power of attorney to report his/her changes in behavior. Both made the decision to transfer him/her to the emergency room to seek medical attention. He/she returned the same evening with no change in treatment.

Tenant #3 continued to experience verbal aggressiveness, visual hallucinations and paranoia following the emergency room visit. On 6-15-11 he/she told the nurse "little men" resided in his/her apartment and Tenant #3 reported a belief he/she paid rent on four different apartments within the program. On 6-16-11, early in the morning, a program staff member found Tenant #3 in Tenant #2's apartment engaging in nonconsensual sexual interaction. Tenant #2 scored a 6 on the GDS scale, indicating severe cognitive decline. Program staff members removed Tenant #3 from the building immediately, transferring him/her to psychiatric unit for evaluation. The Director contacted the local police department, reporting Tenant #3's nonconsensual sexual interaction with Tenant #2.

A detective began an investigation into the encounter however did not complete a report or file any charges secondary to both Tenants cognitive decline.

Tenant #3 had not returned to the program prior to 6-20-11, at which time the Director notified Tenant #3's DPOA that the tenant would not be able to return to the program following discharge from the evaluation due to the aggressive sexual behaviors noted.

The program timely identified Tenant #3's abrupt change in cognitive status, reporting the changes to Tenant #3's DPOA and the physician. Review of clinical records and interview with Staff #1, Staff #2 and the Director revealed Tenant #3 had not shown any aggressive behavior toward other tenants or participated in disruption affecting other tenants from the initial cognitive changes through May 2011. The program successfully intervened when Tenant #3 wandered into Tenant #1's apartment. Tenant #3 had never exhibited aggressive behavior or sexual inappropriateness with other tenant s prior to the incident involving Tenant #2 on 6-16-11. The program reported the incident appropriately to the DPOA, physician's and police department. The program reported the incident to the department appropriately. The monitors found no indication of program culpability.

- Regulatory Insufficiency: None noted.

Dated this 30th day of June 2011.