IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 35352-I
Complaint Intake #: 35392-C

October 3, 2011

Ms. Kris Trotter, Director
Bickford Cottage
5101 University Avenue
Cedar Falls, IA 50613

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

Dear Ms. Trotter:

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, 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
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Incident Intake #: 35352-I
Complaint Intake # 35392-C

Kris Trotter, Director
Bickford Cottage
5101 University Avenue
Cedar Falls, IA 50613

Date of Incident/Complaint Investigation:

August 30, 2011

Monitor(s):

Lori Miner, RN BSN

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:

A complaint/incident investigation was conducted at Bickford Cottage on August 30, 2011. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	36
Current number of tenants with cognitive disorder:	4
Total Population:	40

Dementia Specific Program (DSP)* – **Not applicable.**

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

Program History – The program received regulatory insufficiencies in the areas of Dementia Specific Education and Record Checks during the Recertification and Incident Investigation (32166-I) of January 2011.

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

A. Occupancy Agreement

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #1 (the Tenant), a 45 year-old, was admitted on 6-22-10 and had diagnoses of: Parkinson's, Depression, Anxiety, Mood Disorder, and Hypertension. The Tenant scored 30 of 30 on the Mini Mental State Examination. The Tenant was given a 30-day notice following two incidents of inappropriate language to other tenants, the Tenant's self-report of keeping left over weekend medications in the apartment, and an incident of self-inflicted injury.
  The occupancy agreement was reviewed. The agreement had a document date of 12/09 and the attached Bill of Rights had a date of 4/09. Both were signed by the Tenant and legal representative on 6-23-10. The occupancy agreement was not updated to meet current regulations including but not limited to exception to a 30-day notice, required telephone numbers, and the internal appeals process.

  The Program did not provide the Tenant with the current written information and/or obtain signatures indicating agreement to the terms noted.

- Regulatory Insufficiency: In addition to the requirements of Iowa Code section 231C.5, the written occupancy agreement shall include, but not be limited to, the following information in the body of the agreement or in the supporting documents and attachments: The telephone number for filing a complaint with the department, the telephone number for the office of the tenant advocate, the telephone number for reporting dependent adult abuse, a copy of the program's statement on tenants' rights, a statement that the tenant landlord law applies to assisted living programs, and a

statement that the program will notify the tenant at least 90 days in advance of any planned program cessation, which includes voluntary decertification, except in cases of emergency. (IAC r. 481-69.21(2)(a-f))

B. Criteria for admission and retention of Tenants

Incident Allegation: The Program reported Tenant #1 used a piece of glass to cut his/her wrist on 8-6-11.

- Monitoring Observation: The incident was appropriately reported to the Department within 24 hours. Tenant #1 (the Tenant) was admitted to the program on 6-22-10. A history and physical completed by a physician and dated 6-3-10 detailed assaultive, sexual, and suicidal behavior. It was noted a previous suicide attempt was by overdose. Documentation in the chart also revealed the Tenant had been assigned a probation officer. Passes outside the Program were dictated by the court.
  On 7-28-11, Tenant #1 came to the dining room with a "boom box" and proceeded to turn up the volume "full blast." Another tenant told Tenant #1 to turn off the music because it was upsetting to the others. Tenant #1 replied "Who made you boss?" and then proceeded to call the other tenant a "bastard." On 8-1-11, the Tenant came to the dining room with his "big radio" and turned it on "real loud." A tenant asked the Tenant to turn it off. The Tenant used the word "bitch" three times and then approached the table with the other tenant and glared. The Tenant picked up bingo chips and the other tenant thought he/she was going to be hit with the chips. A meeting was held with the Tenant, the Tenant's legal representative, the probation officer, the Nurse, and the Director. Guidelines for admission and discharge were discussed. The Tenant and legal representative were made aware of expectations and rules and that a 30-day notice would be given if the Tenant was unable to control behaviors. On 8-4-11, the Tenant reported keeping Ativan, for anxiety, and Ambien, for sleep, collected from previous passes from the Program; the medications were found in the Tenant's possession on 8-5-11. On 8-5-11, the probation officer canceled the Tenant's scheduled weekend pass. The Tenant was found on 8-6-11 bleeding from the wrist; a small piece of glass was used to cut the wrist. The Tenant notified family prior to transfer to the hospital. The Program gave the Tenant a 30-day notice on 8-8-11.

- Regulatory Insufficiency: None noted.

C. Program Initiated Involuntary Transfer

Complaint Allegation: It was alleged the Program initiated an involuntary transfer.

- Monitoring Observation: Three charts of recently discharged tenants were reviewed. There was no documentation that an involuntary discharge was initiated.

  The Program gave a 30-day notice to Tenant #1 on 8-8-11. The letter to the legal representative stated the "resident may be discharged involuntarily due to medical or behavioral reasons..." The Program provided documentation of notification sent to the Tenant's physician and legal representative. There was no documentation of notification to the tenant advocate.

- Regulatory Insufficiency: If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply: the program shall immediately provide to the tenant advocate, by certified mail, a copy of the notification and notify the tenant's treating physician, if any. (IAC r. 481-69.24(1)(b))

D. Service Plan

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #1 was admitted on 6-22-10. The Tenant had a history of aggressive behavior and a suicide attempt by overdose. The Tenant worked with a probation officer. Passes out of the Program were dictated by the court. The Program indicated when the Tenant went out, medications were given to the legal representative to administer. The Tenant had two incidents of inappropriate behavior and language with other tenants. The Director revealed the Tenant had exhibited a change since being allowed to go out on pass. The Tenant was encouraged to "vent" to either the Director or the Nurse. The service plan did not identify staff response to inappropriate behavior and language, or that the Tenant was encouraged to talk with the Director or Nurse. The service plan did not identify the role of the probation officer. The service plan did not identify the Tenant was to follow court orders for leaving the Program on passes. The service plan did not direct staff to give medications to the legal representative before passes, or to secure unused medication after a pass. The service plan did not address the Tenant's safety needs related to a history of a suicide attempt. The service plan, dated 7-5-11, was not signed by the Tenant or legal representative.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: the tenant's identified needs and preferences for assistance; and the service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy. (IAC r. 481-69.26(4)(a, c))

E. Nurse Review

During the course of the investigation, the following was noted:

- Monitoring Observation: Progress notes dated 7-5-11 to 8-1-11 showed no documentation of any inappropriate behavior or tenant concerns. On 7-28 and 8-1-11, Tenant #1 was verbally inappropriate to two other tenants. On 8-3-11 the Tenant reported feeling weaker and requested a physical therapy referral. On 8-4-11 the Tenant requested the physician be contacted to see if the prescribed medication Celexa, an antidepressant, was causing hypomanic symptoms. On 8-5-11, the Tenant revealed medication from passes outside the program were kept in the apartment without staff knowledge. A nurse review was not conducted with the change in condition.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation 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))

Dated this 28th day of September, 2011.