IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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LT. GOVERNOR

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**Complaint/Incident Intake #: 36694-C**

December 21, 2011

Ms. Nicole Valladolid, Director
Bickford Memory Care
4022 Indian Hills Drive
Sioux City, IA 51108

**RE: Final Complaint/Incident Investigation Report – Bickford Memory Care, Sioux City, IA**

Dear Ms. Valladolid:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of December 14, 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

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# IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
## Assisted Living Program
## Final Complaint/Incident Investigation Report

**Assisted Living Program:**

**Complaint/Incident Intake #: 36694-C**

Nicole Valladolid, Director
Bickford Memory Care
4022 Indian Hills Drive
Sioux City, IA 51108

**Date of Complaint/Incident Investigation:**

December 14, 2011

**Monitor(s):**

Lori Miner, RN BSN

**Definitions:** ***The following definitions are relevant:***

**Assisted Living Program** – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

**Dementia-Specific Assisted Living Program** - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

**Regulatory Insufficiency** - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

**Overview:** ***In preparing this report, the following information was considered:***

**Current Program Census**

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

| **Dementia-Specific Program by Dedication** | |
|---|---|
| Number of tenants without cognitive disorder: | 0 |
| Number of tenants with cognitive disorder: | 25 |
| Total Population of Program at time of on-site | 25 |
| **TOTAL census of Assisted Living Program** | 25 |

**Program History** – The program received no regulatory insufficiencies during this recertification period.

**Complaint/Incident Investigation** – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

**A. Evaluation**

Complaint/Incident Allegation: It was alleged the Program did not adequately assess tenants for change of condition or physical needs.

- Monitoring Observation: Four tenant files were reviewed. All four tenants were admitted to a hospice program.

  Tenant #1 (the Tenant), a 91 year-old, was admitted to the Program on 4-10-09 and had diagnoses of Alzheimer's Dementia, Hypertension (HTN), Irritable Bowel Syndrome, and Atrial Fibrillation. The Tenant was staged at six on the Global Deterioration Scale (GDS) which indicated severe cognitive decline. The Tenant was admitted to hospice on 5-31-11for Clinical Decline. Besides documentation by the Program Nurse in the progress notes, the clinical record also contained four nurse reviews completed during the month of August 2011 documenting changes in the Tenant's condition. Progress notes documented communication between the Program Nurse and hospice. Functional, cognitive, and health evaluations were completed twice in September 2011. The service plan was last updated on 9-12-11 and was based on evaluations. The service plan indicated the services provided by hospice. The hospice service plan and hospice visit notes were contained in the Program chart. The Program service plan reflected the needs identified in the hospice care plan. The service plan identified the need for assistance with all activities of daily living (ADLs), nutritional needs related to weight loss and interventions as the Tenant was at risk for falls. The Program used a task sheet to document repositioning and oral cares every two hours. The Tenant had been rapidly declining and died on 9-15-11.

Tenant #2 (the Tenant), a 79 year-old, was admitted to the Program on 9-19-09 and had diagnoses of Dementia with Anxiety and Agitation, Chronic Back Pain, and Depression. The Tenant was staged at six on the GDS which indicated severe cognitive decline. The Tenant was admitted to hospice on 12-2-10 for Clinical Decline. Besides documentation by the Program Nurse in the progress notes, the clinical record also contained two nurse reviews completed during the month of August 2011 documenting changes in the Tenant's condition. Progress notes documented communication between the Program Nurse and hospice. Functional, cognitive, and health evaluations were completed on 8-30-11; the service plan was updated and based on those evaluations. The service plan indicated the services provided by hospice. The hospice service plan and hospice visit notes were contained in the Program chart. The Program service plan reflected the needs identified in the hospice care plan. The service plan identified the need for assistance with all ADLs, nutritional needs related to weight loss, and interventions as the Tenant was as risk for skin breakdown. The service plan also identified the Tenant's use of oxygen. The Hospice Nurse reported she had observed staff members feeding and offering fluids to Tenant #2 on several occasions. The Program used a task sheet to document repositioning, oral cares, and toileting every two hours. Hospice progress notes dated 9-6-11 indicated the Tenant was showing a slow decline in condition. Progress notes dated 9-27-11 and indicated as a late entry for 9-26-11 were completed by the Program Nurse. In an interview, the Program Nurse stated she was not working on 9-26-11 but was available by phone. The Program Nurse stated she had received a message from the Tenant's family member on 9-26-11 and had called the Hospice Nurse to ask her to check on the Tenant. Documentation by the Program Nurse indicated the Hospice Nurse was in the building at that time. The Hospice Nurse made a routine visit to the Tenant on the morning of 9-26-11. According to the documentation of that visit, vital signs were checked at 11:15 a.m. The Hospice Nurse indicated in an interview that vital signs were normal and she did not think death was imminent at the time of this visit. The visit notes indicated the Hospice Nurse had been informed by the hospice aide that the Tenant had complained of difficulty breathing during the aide's visit. The Hospice Nurse indicated the Tenant had received a bath from the aide. The hospice visit notes documented the Tenant was sitting in the recliner resting comfortably with oxygen on. The Tenant denied pain or discomfort at the time of the visit. Staff #2 indicated the Tenant was not in pain and was not short of breath the morning of 9-26-11. Staff #2 indicated if the Tenant had pain, it was back pain, but the Tenant did not complain of pain the morning of 9-26-11. Staff #3 indicated the Tenant was not having pain on 9-26-11 and seemed calm and comfortable. Staff #1 reported the Tenant seemed anxious, but went out to the dining room for lunch. The Tenant was returned to his/her room after lunch and was seated in the recliner. The Hospice Nurse indicated she got a message that the Tenant's family member wanted to be called. The Hospice Nurse returned to see the Tenant. In an interview with Staff #1, she believed the Hospice Nurse was already in the building and returned to the room. The Hospice Nurse stated the Tenant was complaining of a non-specific pain, and she asked staff to administer pain medication. The Tenant was settled into bed with oxygen and the Tenant took a sudden turn for the worse. Immediately, the Hospice Nurse asked Staff #1 to notify the family; approximately 1:15 p.m. Staff #1 stated the Tenant's condition changed quickly and within half an hour, the Tenant died. Staff #3 stated the Tenant was taking breaths "like before they pass" and she described it as "short of breath." Staff #3 stated the Hospice Nurse was present when the Tenant was "short of breath."

The Hospice Nurse stated the Tenant's death on 9-26-11 was sudden and unexpected on that particular day. The Hospice Nurse reported that she was present at the time of the Tenant's death at 1:45 p.m. on 9-26-11, as well as Staff #1 and the Tenant's cat. The Hospice Nurse reported the Tenant was comfortable at the time of death.

Tenant #3 (the Tenant), a 90 year-old, was admitted to the Program on 3-11-11 and had diagnoses of Dementia and HTN. The Tenant was staged at five on the GDS which indicated moderately severe cognitive decline. The Tenant was admitted to hospice on 11-28-11 for Debility. Besides documentation by the Program Nurse in the progress notes, the clinical record contained a quarterly nurse review. Progress notes documented communication between the Program Nurse and hospice. Functional, cognitive, and health evaluations were completed and the service plan was updated on 11-29-11. The service plan indicated services provided by hospice. The hospice service plan was contained in the Program chart. The Program service plan reflected the needs identified in the hospice care plan. The service plan identified the need for assistance with all ADLs, nutritional needs related to weight loss, and interventions as the Tenant was as risk for Urinary Tract Infections and falls. The Tenant was observed sitting in the living room during the onsite visit.

Tenant #4 (the Tenant), a78 year-old, was admitted to the Program on 5-10-11 and had diagnoses of Dementia, Agitation, and Weight Loss. The Tenant was staged at six on the GDS which indicated severe cognitive decline. The Tenant was admitted to hospice on 7-27-11 for Alzheimer's disease. Besides documentation by the Program Nurse in the progress notes, the clinical record contained a quarterly nurse review on 12-5-11 and a nurse review for skin breakdown on 12-9-11. Topical treatment and a turn schedule were initiated. A task sheet was used to document turning/incontinence care every two hours and offering fluids. In an interview with the Hospice Nurse, she stated the Program had been monitoring the Tenant and had notified her of the skin breakdown. The Progress notes documented communication between the Program Nurse and hospice. Functional, cognitive, and health evaluations were completed and the service plan updated on 12-5-11. The service plan indicated services provided by hospice. The hospice service plan was contained in the Program chart. The Program service plan reflected the needs identified in the hospice care plan. The service plan identified the need for assistance with all ADLs, and interventions as the Tenant was at risk for Urinary Tract Infections and falls. The Tenant was observed in bed, positioned on side, propped on pillows with a mattress on the floor for fall protection. Alarms were in place.

The Hospice Nurse was interviewed. She stated she had recently cared for five tenants from the Program. The Hospice Nurse stated she collaborated with the Program Nurse on all of the tenants in hospice and thought that the cares outlined in the hospice care plans were carried out by the Program. The Hospice Nurse stated she varied the time of day that her visits were made and her visits were unannounced.

During the onsite visit, this monitor observed 23 tenants in the dining room for the noon meal. The general appearance of the tenants was neat and clean. No body odors were noted.

A group of tenants was noted to be in the living room of the Program for about an hour between 1:00-2:00 p.m. The furniture in the living room was checked for wetness after the tenants left the room. The furniture was dry. Tenants were observed to have dry clothing. The tenants were noted to have shoes and socks on. There was no evidence of incontinence noted.

This monitor took a tour of the building. No odors were noted that were suggestive of urine or stool.

During the afternoon of the onsite visit, staff was noted to be attending to the tenant's nails by cleaning, painting, and trimming them. Staff #1 stated that every Wednesday is nail care day. Throughout the day, this monitor observed tenants' nails. Nails appeared to be clean.

During interviews, Staff #1, #2, and #3 indicated that all cares are completed. Bathing, toileting, and hygiene are completed and there have been no instances of cares not being provided. All three staff reported the same toileting schedule. The staff members stated that no tenants are left to sit in wet or soiled undergarments. Because of the toileting schedule, all undergarments are checked and changed often. All three staff members indicated call lights are answered quickly. Tenants were rarely found on the floor. All three staff members described the procedure to follow in the event a tenant falls. The staff members indicated the Program Nurse would be notified and an incident report completed.

In summary, four tenant files were reviewed for documentation of the completion of assessment related to change in condition. Tenant files contained documentation of nurse reviews as well as evaluations of functional, cognitive, and health status. Service plans were current and incorporated hospice needs. Interviews were conducted with the Hospice Nurse and Program staff. All indicated that cares needed were provided. Tenant observations were made. Tenants appeared neat and clean.

- Regulatory Insufficiency: None noted.