IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 36421-I

December 20, 2011

Ms. Emily Elmendorf, Director
Bickford Senior Living
3500 Lower West Branch Road
Iowa City, IA 52245

RE: Final Complaint/Incident Investigation Report, Bickford Senior Living, Iowa City, Iowa

Dear Ms. Elmendorf:

Enclosed is the **Final Complaint/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/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiency, 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

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

Assisted Living Program:

Emily Elmendorf, Director
Bickford Senior Living
3500 Lower West Branch Road
Iowa City, IA 52245

Complaint/Incident Intake #: 36421-I

Date of Complaint/Incident Investigation:

November 9 & 14, 2011

Monitor(s):

Stephanie Cummins, MA
Maribeth Freland, RN
Joyce Kix, RN

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 Definition	
Number of tenants without cognitive disorder:	27
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	36
TOTAL census of Assisted Living Program	36

Program History –

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

A. Service Plans

Complaint/Incident Allegation: The Program reported a tenant was found outside on the front porch. The Program reported he/she was dressed appropriately for the weather. The alarm did not go off when the tenant left but it did sound when staff brought the tenant back into the building.

- Monitoring Observation: Tenant #1 (the Tenant), a 95 year old, was admitted on 3-28-09 and diagnoses include Atrial Fibrillation, Benign Prostate Hypertrophy, Falling Episodes, Frontal Intraparenchymal Hemorrhage, Hypertension (HTN), Hypercholesterolemia and Transient Ischemic Attack. The Tenant was staged at five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline.

  Staff #1 completed an Incident Report related to the elopement. According to an Incident Report dated 10-23-11 at 11:30 a.m. Staff #1 overheard another tenant state to another staff member that there was a person in a wheelchair coming up. The other staff member went towards the front and she followed. Two other tenants were headed out the door with family and they followed them outside. The Tenant was partially on the parking lot and porch facing the door of the building. Staff #1 pushed the Tenant inside and Staff #2 held the door. The alarm did not sound upon arrival at the door but did sound when staff brought the Tenant back into the building. The Director was notified by phone of the incident on 10-23-11 and the Director spoke with the Tenant's family.

Staff #2 completed an Incident Report related to the elopement. According to an Incident Report dated 10-23-11 at 11:30 a.m. Staff #2 stated the Tenant was seen outside the door by another tenant and commented to Staff #2 that there was a person outside the door. She looked through the window and saw the Tenant in a wheelchair rolling up to the door. Staff #1 was verbally notified and the Tenant was assisted back into the building.

Staff #1 did not know exactly how long the Tenant was outside the building because it could not be determined but she estimated approximately five minutes. She was not aware of other elopements with the Tenant. Staff #2 stated the Tenant could not have been outside more than 10-15 minutes because she saw the Tenant at approximately 11:00 a.m. She was not aware of any other elopements with the Tenant. The Director stated the Tenant was outside approximately 5 to 10 minutes. She was not aware of other elopements with the Tenant. The Nurse said the Tenant could not have been outside more than 10 minutes because he/she was visualized by staff 10 minutes prior.

According to a Program record, the Tenant was wearing a blue jacket and weather appropriate clothing at the time of the incident. The Tenant did not sustain any injuries and the Tenant was in good spirits. The Director contacted the Director of Property Management to review the electronic monitoring system logs. The logs showed that the alarm had not registered when the Tenant went out of the building. The logs showed the monitoring system did register upon bringing the Tenant back into the building. According to the a Program record, an additional monitor would be installed on the door and a new electronic monitoring watch was put on the Tenant.

The Director of Property Management indicated the individual electronic monitoring wristwatch did not function at the time the Tenant eloped. The watch was tested after the incident occurred and worked on an intermittent basis. A new watch was put on the Tenant.

According to a Program policy, the electronic monitoring system was required to be inspected weekly to ensure it functioned appropriately. Records indicated the electronic monitoring system was checked consistently every week for the past three months.

According to the State Climatologist, on 10-23-11 at 11:52 a.m. the temperature was 63 degrees, humidity was 56 percent, there was a west south west wind at 9 miles per hour, cloudy skies and there was no rainfall that day. The low for 10-23-11 was 39 degrees and the high was 79 degrees.

The Tenant's service plan did not indicate the electronic monitoring wristwatch and the watch did not function at the time of the elopement. The service plan did not reflect the identified needs of the tenant.

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

Tenant #2 (the Tenant), a 69 year old, was admitted on 1-8-11 and diagnoses include HTN, Hyperlipidemia, Depression, Anxiety, Alopecia, Myopathy and Dementia. The Tenant was staged at a five to six on the GDS, which indicated moderately severe to

severe cognitive decline. Progress Notes dated 9-13-11 indicated the Tenant was found lying in another tenant's bed on top of the blanket next to the other tenant. Both tenants were fully clothed. The Tenant was redirected back to his/her apartment. On 9-15-11 the Tenant was found lying on a bed in another tenant's apartment. According to notes on 10-24-11 the Tenant had gone into another tenant's apartment and had handprints of bowel movement on carpet, walls and door. The Tenant's service plan did not reflect the behavior of entering other tenant apartments. The service plan did not reflect the identified needs of the tenant.

Tenant #3, a 78 year old, was admitted on 7-24-11 and diagnoses include Mild Dementia, Memory Disturbance and HTN. The Tenant was staged at a four on the GDS, which indicated moderate cognitive impairment. According to a Program record, the Tenant wore an electronic monitoring wristwatch. According to a statement signed by Director, the Tenant had a history of holding doors open for visitors and guests. The watch and history of holding doors open for others was not reflected on the service plan. The Nurse said the Tenant's spouse set up the Tenant's scheduled medications in a medication planner and staff administered the medications per the planner. The Tenant also had as needed medications that were administered per pill bottle by staff. The Tenant's service plan did not reflect the Tenant's spouse setting up medications. The service plan did not reflect the identified needs of the tenant.

- Regulatory Insufficiency: The service plan shall be individualize and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))