IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 38029-I

March 14, 2012

Ms. Laura Brock, Administrator
Bickford Cottage Assisted Living
4040 E. 55th Street
Davenport, IA 52807

RE: Final Complaint & Incident Investigtion Report – Bickford Cottage Assisted Living, Davenport, IA

Dear Ms. Brock:

Enclosed is the **Final Complaint & Incident Investigation Report** from the on-site monitoring visit of February 28 & 29, 2012, 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 #:** 38029-I

Laura Brock, Administrator
Bickford Cottage Assisted Living
4040 East 55th Street
Davenport, IA 52807

Date of Complaint/Incident Investigation:

February 28 & 29, 2012

Monitor(s):

Hal L. Chase, RN BSN MPH

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.

General Population Program	
Number of tenants without cognitive disorder:	16
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	20
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	6
TOTAL census of Assisted Living Program	26

Program History – The program received regulatory insufficiencies during this certification period in the area of Dementia Specific Education.

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

A. Tenant Rights

Complaint/Incident Allegation: On 2-23-12, the Program reported Tenant #1 alleged a man came into his/her room at night and molested him/her. Later that evening, Tenant #1 identified Staff #3. Staff #3 was removed from the dementia unit and was suspended from employment.

- Monitoring Observation: Six tenants resided in the dementia unit. Three of the tenants residing in the unit were the opposite gender of Tenant #1. Four tenant files were reviewed. No issues were found with three of the tenant files reviewed.

  Tenant #1, a 79 year-old, was admitted on 1-6-12 and had diagnoses of: Dementia, Hypertension and Hyperlipidemia. Tenant #1 resided in the dementia unit. Tenant #1 was staged at three + on the Global Deterioration Scale (GDS), indicating mild cognitive impairment.

  An initial service plan of 1-5-12 and subsequent updated service plan of 2-1-12 indicated Tenant #1 required assistance with activities of daily living (ADLs), including staff assistance with bathing, grooming, dressing and toileting. Tenant #1 was incontinent of urine and stool and wore incontinent undergarments. Tenant #1 would often toilet independently, but needed staff assistance with peri-care after having a bowel movement and needed assistance with changing his/her incontinent undergarments.

Progress notes of 1-6-12 through 2-18-12 indicated Tenant #1 was anxious and continuously attempted to exit the Program. Tenant #1 would tell staff he/she wanted to go home. Service plans of 1-5-12 and 2-12-12 established interventions related to exit seeking. Staff was to engage Tenant #1 in activities that interested Tenant #1. Tenant #1 was not successful in eloping from the Program.

A physician's order of 2-9-12 indicated Tenant #1 was prescribed Seroquel – 50mg tablet – one half tablet each evening. Medication Administration Records (MARs) of 2-9-12 through 2-23-12 indicated Tenant #1 received this medication each evening. Resident service notes of 2-17-12 through 2-22-12 indicated at least three incidents of falls and feeling dizzy. On 2-23-12 Seroquel was discontinued due to falls and dizziness. Tenant #1 was started on Namenda – 5 mg daily.

On 2-18-12 Staff #2 relieved Staff #3 for dinner at approximately 8:30 p.m. Staff #2 was administering medications to tenants and Tenant #1 reported he/she "was molested by a tall guy with black hair." When Staff #3 returned from his dinner break he saw Tenant #1 point at him and reported to Staff #2 "that's him."

Staff #2 contacted the Program Administrator of the incident. The Administrator instructed Staff #3 to leave the dementia unit and to document his interactions with Tenant #1 that evening. The Administrator instructed Staff #2 to document the incident. Staff #1 was instructed to replace Staff #3 on the dementia unit and to document Tenant #1's behavior or "anything out of the ordinary." Staff #1 reported Tenant #1 rested peacefully during the night hours.

According to the Program's internal investigation, Staff #3 reported Tenant #1 had a bowel movement earlier in the evening of 2-18-12 and needed assistance with peri-care and changing of incontinent undergarments. Staff #3 reported Tenant #1 didn't seem uneasy with this care.

On 2-19-12, Tenant #1 reported to Staff #6, his/her back hurt. A man broke into his/her room and smacked him/her in the face and pushed him/her up against the door. Staff #6 took Tenant #1 to the restroom, checked Tenant #1's body and noted no bruises or marks. The Administrator met with Tenant #1 in his/her apartment. Tenant #1 reported, (citing a person's name, but not staff) had broken into his/her motel room and hitting him/her on the back. The Administrator looked at Tenant #1's back and noted no marks or bruising.

The Administrator contacted Tenant #1's guardian of the incident. The guardian reported prior to Tenant #1's moving to the Program, Tenant #1 had been saying a lot of bizarre things. Tenant #1 lived in an assisted living program prior to moving to this Program and staff had found Tenant #1 in other tenant's beds and reported tenants of the opposite sex were getting in bed with him/her. Tenant #1 had also accused the guardian of "doing something bad."

Tenant #1's record indicated prior to moving to this Program, Tenant #1 had lived at a sister assisted living program. Progress notes from the other program confirmed the above incidents.

On 2-20-12, the on-call registered nurse (RN) completed a health and functional evaluation and found no signs of bruising or redness, including Tenant #1's "private area." The RN found "an old bruise" on the right mid-upper arm. The RN reported Tenant #1 had smearing of feces and soiled incontinent undergarments. Peri-care and assistance with changing his/her incontinent undergarments was given. The RN asked if anyone had been mean to him/her, if anyone had tried to touch his/her private area. Tenant #1 reported "no, everyone is always very nice."

On 2-23-12, Tenant #1's physician was notified of the above incident. As of this writing, Tenant # 1's physician hadn't responded.

Tenant #1 was interviewed by a monitor. Tenant #1 was oriented to name only. Tenant #1 reported he/she liked the Program, but wanted to go home. Tenant #1 reported he/she liked working outside and wished he/she could leave and didn't know why he/she couldn't leave. During this interview Tenant #1 started to speak in German and couldn't be understood. Tenant #1 reported staff treated him/her "okay," and needed their assistance to help him/her, but didn't elaborate further. Tenant #1 reported feeling safe and had "no worries." Tenant #1 was asked if anyone touched him/her badly or treated him/her badly. Tenant #1 reported "No."

On 2-28-12, Tenant #1's guardian was interviewed and reported Tenant #1 had a history of hallucinations. Prior to living at an assisted living program Tenant #1 lived at home. Over the past 12 months Tenant #1 had "dramatic changes." Tenant #1 would believe his/her sister was outside and he/she would often leave his/her home in search of his/her sister. The guardian reported Tenant #1's sister lived outside the United States. Tenant #1 had lived at a sister program in another city, but was moved to this Program as this Program had a dedicated dementia unit. The guardian reported he/she didn't "believe the validity of the allegations."

Staff #1 was interviewed and reported Tenant #1 had hallucinations since his/her admission. Tenant #1 believed he/she see her sister outside and believe there were tenants of the opposite sex in his/her apartment. Tenant #1 would often go into other tenant's apartment, believing it was his/hers, undress and get into bed. Tenant #1 would sleep in the nude, but would be covered with bed linens. A tenant would come into his/her apartment, see Tenant #1 in his/her bed and Tenant #1 would tell the tenant to leave. Staff would dress Tenant #1 and escort the Tenant #1 out of the other tenant's apartment. Staff #1 reported she had not seen any staff, including the two male staff act or treat Tenant #1 inappropriately.

Staff #2 was interviewed and reported Tenant had a history of hallucinations. Tenant #1 would believe his/her sister was outside and would then try to exit the Program. Tenant #1 had been confused, often going into other tenant's apartment and believing he/she was in his/her own apartment. On 2-18-12, at approximately 8:00 p.m., she arrived in the dementia unit to relieve Staff #3 for dinner. Staff #2 was administering medications to tenants when Tenant #1 told her a man had molested him/her. When Staff #3 returned, Tenant #1 pointed to Staff #3 and reported "that's the guy." Staff #2 called the Administrator and was given instruction to have Staff #3 leave the dementia unit and have Staff #6 work in the dementia unit. Staff #2 reported she hadn't seen any staff treat Tenant #1 inappropriately.

Staff #3 was interviewed and reported he arrived at work at 3:00 p.m. and worked in the dementia unit. Staff from the previous shift gave oral report and reported Tenant #1 was exit seeking and it was harder than normal to redirect Tenant #1. Staff #3 reported at approximately 6:30 p.m. he assisted Tenant #1 with toileting, as Tenant #1 was soiled with urine and feces. Staff #3 assisted with cleaning and changing incontinent undergarments. At approximately 8:00 p.m., he went on break. When he returned at 8:30 p.m. he saw Tenant #1 point in his direction. Staff #2 spoke to him and told him Tenant #1 had reported he had molested him/her. Staff #3 reported he was directed to leave the dementia unit. Staff #3 reported he has not returned to the dementia unit.

The Program has two male staff who provide personal and health related cares. Staff #3 was hired on 8-20-11. Criminal background, sex offender and child and dependent adult abuse checks were completed on 8-5-11. Staff #3 was not found in any of the registries. Personnel records indicated Staff #3 received nurse delegated training on 8-20-11, dependent adult abuse training on 4-4-08 and eight hours of dementia training on 12-9-11. Staff #3 worked primarily in the dementia unit.

Staff #4 was hired on 8-20-11. Criminal background, sex offender and child and dependent adult abuse checks were completed on 4-20-09. Staff #4 was not found in any of the registries. Personnel records indicated Staff #4 received annual nurse delegated training on 8-20-11, dependent adult abuse training on 4-4-08 and eight hours of dementia training on 12-9-11. Staff #4 worked primarily in the dementia unit since his hire of 8-20-11.

Staff #4 was interviewed and reported he worked in the general population of the Program and rarely worked in the dementia unit. He would relieve staff in the dementia unit for breaks and would return to the general population. Staff #4 reported he knew Tenant #1 had a history of exit seeking from the dementia unit. Tenant #1 would often say his/her sister was outside and wanted to go to her. Staff in the dementia unit had reported Tenant #1 needed assistance with toileting, usually after a bowel movement and needed assistance with wiping and changing of incontinent undergarments. Tenant #1 hadn't reported any concerns to him. Tenant #1 was a private person when it came to personal cares like toileting, bathing and dressing. Staff #4 reported he hadn't heard or seen anyone treat Tenant #1 inappropriately. According to the Program's schedule, Staff #4 did not work the evening of 2-18-12.

Staff #5 worked primarily in the dementia unit, five out of six shifts per week. She had been with the Program since 2002. She was interviewed and reported Tenant #1 was anxious and would often push on the exit doors of the dementia unit. Tenant #1 would often state he/she wanted to go home. Tenant #1 would often become more anxious after lunch. Tenant #1 needed assistance with ADLs, including toileting. Tenant #1 would often smear feces and needed wiping and cleaning of the peri-area, as Tenant #1 doesn't wipe correctly. Staff #5 reported Tenant #1 would wander into other tenant's apartment and believed tenants who resided in the Program were his/her father. Staff #5 reported Tenant #1 had never told her of being touched inappropriately by staff or other tenants. Staff #5 reported she hadn't seen any staff treat Tenant #1 inappropriately.

On 2-18-12, Tenant #1 reported he/she had been molested by Staff #3. An investigation by a monitor on 2-28 & 2-29-12 was initiated. This investigation included; a review of Tenant #1's past and current status, a review of tenants who were of the opposite sex who resided in the dementia unit, interviews with Tenant #1's guardian, the Program Administrator, RN, and staff who worked in the dementia unit. A review of staff personnel files concluded there was no evidence the incident took place. At the time of the incident, the Program took steps to ensure Tenant #1's safety and the safety of all tenants residing in the dementia unit and general population.

- Regulatory Insufficiency: None noted.