IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

RODNEY A. ROBERTS, DIRECTOR

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

Complaint/Incident Intake #: 38124-I

April 5, 2012

Ms. Angie Cozadd, Director
Bickford Cottage Burlington
3301 Sterling Drive
Burlington, IA 52601

RE: Final Complaint/Incident Investigation Report – Bickford Cottage Burlington, Burlington, IA

Dear Ms. Cozadd:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of April 2, 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

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 Complaint/Incident Investigation Report

Assisted Living Program:

Complaint/Incident Intake #:

38124-I

Angie Cozadd, Director
Bickford Cottage Burlington
3301 Sterling Dr.
Burlington, Iowa 52601

Date of Complaint/Incident Investigation:

April 2, 2012

Monitor(s):

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.

General Population Program	
Number of tenants without cognitive disorder:	35
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	39
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	5
TOTAL census of Assisted Living Program	44

Program History – There were regulatory insufficiencies during this certification period in the area of Service Plans, Staffing, Criteria for Admission and Retention and Structural.

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

Tenant Rights

Complaint/Incident Allegation: It was reported a staff member failed to timely follow up on a tenant request. It was also reported a staff member yelled at a tenant.

- Monitoring Observation: The monitors reviewed the program's medication error reports and incident reports for January to March 2012, finding no concerns. The monitors also reviewed the clinical records of Tenants #1, #2, #3 and #4.

  The program administered pain medications to Tenants #1 and #2. During interview, Tenant #1 reported he/she had no concerns with medication administration. He/she reported staff members routinely administered his/her pain medication within 5 minutes of Tenant #1's request.

  Tenant #2, a 95 year old tenant residing in the general population area, was admitted to the program on 10-12-06 with diagnoses of: Hypertension (HTN); Arthritis; Osteopenia and Lung Cancer. Tenant #2 answered 29 of 30 questions correctly on the program's cognitive assessment screening tool, completed on 1-23-12, indicating no cognitive impairment.

Tenant #2's clinical record indicated he/she began having program staff members assist with administration of only narcotics and pain medications on 2-10-12. The record documented Tenant #2's use of Vicodin and Fentanyl Patch for pain control.

During interview, Tenant #2 reported staff members most often administered his/her pain medications timely; however, on one isolated incident, Staff #1, certified medication aide (CMA), took approximately 45 minutes to bring a Fentanyl Patch after requested by Tenant #2. Tenant #2 could not remember the date of this occurrence. Tenant #2 reported he/she had taken a Vicodin at 6:00 AM, which was effective with pain relief by 7:00 AM. A few minutes later, Tenant #2 attempted to get up independently from bed, noting a significant increase in his/her pain level. He/she summoned a staff member, seeking administration of his/her Fentanyl Patch. Staff #1 was reportedly counting narcotics with the outgoing medication passer at the time of Tenant #2's request. Staff #1 finished narcotic count prior to going to Tenant #2's apartment, at which time she administered the Fentanyl Patch per tenant request. Tenant #2 reported immediate relief of his/her pain symptoms within 10 minutes of application of the patch. Tenant #2 denied any similar delays in medication administration since this incident.

Tenant #2's clinical record documented staff members had administered Vicodin to Tenant #2 at 6:00 AM on 2-26-12. Documentation indicated Tenant #2 reported the Vicodin to be effective with pain relief at approximately 7:00 AM. The clinical record contained a physician's order for Vicodin 7.5 milligram (mg.)/750 mg. one every 4 to 6 hours and a physician's order for Fentanyl Patch (containing a slow released form of pain medication) to be applied topically and replaced every 72 hours. Each patch slowly delivers a small amount of the pain medication for 72 hours. Staff members remove the old patch and immediately replace with a new patch so that the level of medication remains constant. According to Narcotic Sheets, staff members routinely placed the patch at 10:00 AM, as was documented on 2-23-12.

Tenant #2 had reported an escalation in pain shortly after 7:00 AM. Medications are required to be administered no sooner than one hour prior to the scheduled time and no later than one hour after the scheduled time. While Staff #1 had a delay in response to Tenant #2's request for the Fentanyl Patch application, the Fentanyl Patch could not be applied until 9:00 AM due to the regulatory requirements and Tenant #2 still had a Fentanyl Patch in place delivering a dose of the medication, which would not have ceased effectiveness until 10:00 AM. Tenant #2 had taken a Vicodin at 6:00 AM with noted pain relief and could not have another Vicodin until 10:00 AM per regulatory requirements.

The monitors also reviewed the clinical records of Tenants #3 and #4. The Director reported a recent incident involving Staff #2, CMA, speaking to Tenant #3 in a harsh tone. Tenant #3 resided in the secured memory care unit and could not be interviewed. Witness to this incident reported Staff #2 was speaking in a very loud voice when giving Tenant #3 repeated cuing and direction. Tenant #3 required repeated cuing and direction due to short term memory loss.

Staff #2 no longer worked at the program. The witness reported Staff #2 was speaking loudly but did not report any inappropriate verbal interaction. Tenant #3 required repeat cuing and direction due to cognitive issues.

While Staff #2 may have spoken to Tenant #3 louder than required, the monitors found no evidence that inappropriate interaction took place.

Tenant #4, an 87 year old residing in the program's general population area, was admitted on 10-12-06 with the diagnoses of: HTN; Diabetes; Congestive Heart Failure and Peripheral Vascular Disease. Tenant #4 answered 30 of 30 questions on the program's cognitive assessment screening tool, completed on 1-23-12, indicating no cognitive impairment. During interview, Tenant #4 reported Staff #1 "gave him/her a tongue lashing" on 2-26-12. Tenant #4 reported Staff #1 had previously been kind to him/her and he/she thought Staff #1 had a good relationship with him/her prior to this date. Tenant #4 indicated he/she just turned around and left the area after Staff #1 spoke unkindly to him/her. Tenant #4 denied any similar incidents since 2-26-12. During interview, Staff #3, CMA, reported she had witnessed the exchange between Tenant #4 and Staff #1 on 2-26-12. Staff #3 reported Tenant #4 approached Staff #1 in the medication room and appeared upset. Tenant #4 requested assistance in his/her apartment to administer medications to a roommate. Staff #1 spoke calmly when responding to Tenant #4, stating she needed to finish counting the narcotics and would come to the apartment directly when finished with the task. Tenant #4 walked away without any further verbal exchange.

Staff #1 no longer worked at the program. Tenant #4 believed he/she had been spoken to in a disciplinary way by Staff #1. Witnesses reported Staff #1 spoke calmly to Tenant #4 during the exchange; however, Staff #1 told Tenant #4 he/she would need to wait until the staff member finished with the task at hand. Tenant #4 denied this ever happening prior to or after 2-26-12.

- Regulatory Insufficiency: None Noted.