IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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Complaint/Incident Intake #: 38616-I

May 18, 2012

Ms. Laura Brock, Manager
Bickford Cottage Davenport
4040 E. 55th Street
Davenport, IA 52806

RE: Final Complaint/Incident Investigation Report, Bickford Cottage Davenport, Davenport, Iowa

Dear Ms. Brock:

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 Insufficiencies, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Laura Brock, Manager
Bickford Cottage Davenport
4040 E 55th St.
Davenport, Iowa 52806

Complaint/Incident Intake #:

38616-I

Date of Complaint/Incident Investigation:

April 16 and 17, 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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	15
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	20

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	7
TOTAL census of Assisted Living Program	27

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: The program reported a tenant who required use of a personal pad alarm system to assure safety fell, requiring hospitalization.

- Monitoring Observation: The program identified five tenants residing at the program who utilize a personal pad alarm system for safety reasons. The program's personal pad alarm system consisted of an electronic pad placed underneath a tenant when the tenant is either sitting in a chair or lying in bed. The electronic pad can either sound audibly when pressure changes on the pad or can send an electronic signal to the program's pager system notifying staff members via a pager that the tenant had risen unattended from the chair or bed. The program used the pad alarms for those tenants who were unable to independently transfer and ambulate safely and either was unable to use the program's pendant system to request assistance or was routinely forgetting to use the pendant system to request staff member assistance.

  The program's alarm system captured times when the alarm was activated and staff member response times. The Manager reported all times documented with very quick response times could be assumed to be times when staff members were present and assisting the tenant, which would cause the alarm to activate when the tenant stood and then the staff member immediately reset the alarm.

The Manager reported all response times under five minutes would be considered as timely response according to program standards. The Manager also reported she could print response times for monitor review; however, she could not print any response times prior to January 12, 2012 as the system was reset at that time and data from previous dates could not be recovered. The Manager indicated she had not routinely printed off response times for review in the past; however, reported she planned to do so in the future to determine what had occurred to cause delay in response when response times exceeded five minutes.

The monitors reviewed the clinical records of Tenant's #1, #2, #3, #4 and #5, all identified by the program as utilizing the personal pad alarm system, reviewed the program's pad alarm response times for all five tenants, reviewed incident reports associated with falls, made observations, interviewed tenants as able and interviewed staff members who work directly with all five tenants, identifying the following:

Tenant #1, an 84 year old, was admitted to the program on 10-14-12 with the diagnoses of Diabetes, Coronary Artery Disease, Hypertension (HTN) and Legal Blindness. Tenant #1 resided in the general population area of the program. Tenant #1 scored a 4 on the Global Deterioration Scale (GDS) completed on 2-7-12, indicating moderate cognitive decline. Tenant #1's service plan, dated 2-7-12, documented Tenant #1 required staff member assistance with bathing, grooming, dressing, toileting, transferring and ambulation. Tenant #1 often attempted to go to the toilet independently. A pad alarm was initiated to alert staff members to Tenant #1 standing without staff member assistance in an attempt to assure safety for Tenant #1. The service plan documented Tenant #1 began experiencing combativeness with staff members when attempting to assist Tenant #1 with personal care tasks on 3-22-12. The service plan gave direction to leave Tenant #1 when showing these behaviors and return to visually check on Tenant #1 frequently.

The monitors reviewed the program's incident reports for Tenant #1 noting the following:

Tenant #1 attempted to ambulate independently to the bathroom on 12-31-11 at 4:35 a.m. The report indicated the pad alarm sounded but when the staff member arrived at Tenant #1 apartment, Tenant #1 had already gotten to the bathroom and fell, resulting in skin tears to both elbows. The staff member response time could not be recovered.

Tenant #1 attempted to ambulate independently across apartment to answer the telephone on 12-31-12 at 8:00 p.m. The report indicated the pad alarm sounded but when staff members arrived Tenant #1 had fallen onto the floor, resulting in a quarter sized rug burn on one knee. The staff member response time could not be recovered.

Tenant #1 attempted to ambulate independently while in the apartment on 3-30-12 at 10:50 p.m. The report indicated the pad alarm sounded but when the staff member arrived at the apartment, Tenant #1 had already fallen and was lying on the floor in the hallway, resulting in a hip fracture. Tenant #1 was admitted to the hospital for repair of the fractured hip and currently resided in a skilled facility until Tenant #1 could return to the program.

The program's alarm response log indicated staff members responded to the pad alarm activation in less than three minutes.

The alarm response logs from 1-12-12 through 3-30-12 documented 11 response times exceeding five minutes. The documented response times ranged from 5 to 32 minutes.

Tenant #2, an 89 year old, was admitted to the program on 1-5-07 with the diagnoses of Vascular Dementia, Chronic Obstructive Pulmonary Disease and a history of fractures of the pelvis. Tenant #2 resided in the general population area of the program. Tenant #2 scored a 3 on the GDS completed on 2-7-12, indicating mild cognitive decline. Tenant #2's service plan, dated 2-7-12, documented Tenant #2 required staff member assistance with bathing, grooming, dressing, toileting, transferring and ambulation. Tenant #2 attempted to stand independently at times. A pad alarm was initiated to alert staff members to Tenant #2 standing without staff member assistance in an attempt to assure safety for Tenant #2.

The monitors reviewed the program's incident reports for Tenant #2 noting the following:

Tenant #2 attempted to stand independently while in the main common area dining room on 3-2-12 at 4:00 p.m. The report indicated two staff members were in the dining room but had their backs to the area where Tenant #2 was seated. Both heard a "loud thump", turned and observed Tenant #2 lying on the floor, resulting in no injuries. The report lacked any mention of the pad alarm being in place or sounding prior to the fall. During monitor interview, Staff #1, certified nurse aide (CNA), reported she had been present in the dining room when Tenant #2 fell and had completed the incident report following the fall. Staff #1 reported the pad alarm was not under Tenant #2 on 3-2-12 when Tenant #2 stood independently and fell. During monitor interview, the Manager reported staff members do not place the pad alarm under Tenant #2 when out in the common living room or dining room areas as staff members are usually present to observe tenants and felt it a dignity issue to allow other tenants to observe Tenant #2 using the pad alarm.

Tenant #2 attempted to stand independently while in the apartment on 4-9-12 at 9:00 p.m. The report indicated the pad alarm sounded but when staff members arrived Tenant #2 had fallen onto the floor, resulting in no injuries. The program's alarm response log indicated staff members responded to the pad alarm activation in less than two minutes.

The alarm response logs from 3-1-12 through 4-15-12 documented seven response times exceeding five minutes. The documented response times ranged from 5 to 22 minutes.

On 4-16-12 at 4:50 p.m., the monitors observed Tenant #2 sitting in the common area dining room area. The monitor observed no pad alarm placed on the chair under Tenant #2. Staff #2, certified medication aide (CMA), assisted Tenant #2 to stand and ambulate from the dining room to toilet. Approximately ten minutes later, Staff #2 returned Tenant #2 back to the same chair in the dining room.

The monitor continued to note no pad alarm was placed in the chair when Staff #2 assisted Tenant #2 to sit.

Tenant #3, an 89 year old, was admitted to the program on 1-10-09 with the diagnoses of Diabetes, Dementia, HTN and Narcolepsy associated with falls. Tenant #3 resided in the program's memory care unit. Tenant #3 scored a 4 on the GDS completed on 12-14-11 and 3-8-12, indicating moderate cognitive decline. Tenant #3's service plan, dated 3-8-12, documented Tenant #3 required staff member assistance with bathing, grooming, dressing, toileting, transferring and ambulation. Tenant #3 attempted to stand independently at times. In an attempt to assure safety a pad alarm was initiated on 12-1-11 to alert staff members that Tenant #3 was standing without staff member assistance. The service plan also indicated Tenant #3 was gruff, uncooperative with staff members and resistive to assistance with personal care. The service plan directed staff members to leave the tenant if being resistive and reapproach at a later time to complete the task.

The monitors reviewed the program's incident reports for Tenant #3 noting the following:

Tenant #3 attempted to stand independently while in the common area of the memory care unit on 12-16-11 at 6:00 p.m. A staff member washing dishes in the kitchen heard a "thump" and saw Tenant #3 on the floor. Tenant #3 experienced no injuries secondary to the fall. The incident report, completed by Staff #1, CNA, did not say whether a pad alarm was in place or had sounded. On 12-19-11, the program registered nurse (RN) documented on the report that it was unclear whether the pad alarm had sounded. The RN documented direction to staff members that all should assure a pad alarm was in place and was in working condition. During monitor interview, Staff #1 could not remember if the alarm had been in place or if it had sounded.

Tenant #3, while accompanied by Staff #3, licensed practical nurse (LPN), stood up and started leaving the common area of the memory care unit on 3-9-12 at 2:30 p.m. The report indicated Staff #3 took the pad alarm with her and followed Tenant #3 into the apartment. Tenant #3 refused to sit down, going into the bathroom and began grooming. Staff #3 stepped out of Tenant #3's room to redirect another tenant and heard a "boom sound". At 2:49 p.m, Staff #3 returned to Tenant #3's room, finding Tenant #3 on the floor in the bathroom. Tenant #3 reported hitting his/her head, requiring medical evaluation. During monitor interview, the LPN reported she was aware that Tenant #3 was not seated on the pad alarm when she left Tenant #3's room. She indicated another tenant was observed bending over and "getting into the kitty litter box". The LPN reported she left Tenant #3's room to redirect the other tenant from the kitty litter box, cleansing his/her hands and assisting that tenant to sit in the common living room area of the memory care unit prior to returning to Tenant #3's room.

The alarm response logs from 2-1-12 through 4-15-12 documented five response times exceeding five minutes. The documented response times ranged from 5 to 23 minutes. On 4-16-12 the monitors made two observations of Tenant #3, finding a pad alarm in place and functioning appropriately.

Tenant #4, an 86 year old, was admitted to the program on 3-5-11 with the diagnoses of Alzheimer's Dementia, HTN, Osteoporosis and a history of Compression Fractures of the Spine. Tenant #4 resided in the general population area of the program. Tenant #4 scored a 4 on the GDS completed on 3-26-12, indicating moderate cognitive decline. Tenant #4's service plan, dated 3-26-12, documented Tenant #4 required staff member assistance with bathing, grooming, dressing, toileting, transferring and ambulation. Tenant #4 attempted to stand independently at times. In an attempt to assure safety a pad alarm was initiated when Tenant #4 was alone in the apartment to alert staff members to standing without staff member assistance. Tenant #4 had not experienced any falls in the previous three months.

The alarm response logs from 3-1-12 through 4-15-12 documented 18 response times exceeding five minutes. The documented response times ranged from 5 to 12 minutes.

Tenant #5, an 85 year old, was admitted to the program on 9-20-11 with the diagnoses of Dementia, HTN, Coronary Artery Disease and history of Stroke. Tenant #5 resided in the general population area of the program. Tenant #5 scored a 3 on the GDS completed on 3-28-12, indicating mild cognitive decline. Tenant #5's service plan, dated 3-28-12, documented Tenant #5 required staff member assistance with bathing, grooming, dressing, transferring and ambulation. Tenant #5 attempted to stand independently at times. Tenant #5 could use a pendant alarm to summon staff; however, due to many attempts to stand without using the pendant alarm, a pad alarm was initiated on 2-21-12.

The monitors reviewed the program's incident reports for Tenant #5 noting the following:

Tenant #5 attempted to stand independently while in the room. The pad alarm sounded. When staff members responded, they found Tenant #5 sitting on the floor next to the chair. Tenant #5 indicated he/she "missed the chair", falling to the floor, resulting in no injuries. The program's alarm response log indicated staff members responded to the pad alarm activation in less than two minutes.

Tenant #5 pushed the pendant button at 3:03 p.m. on 3-22-12 in an attempt to summon staff members for assistance. Tenant #5's pad alarm sounded at 3:21 p.m. Staff responded in less than one minute to the pad alarm alert to find Tenant #5 on the floor at the end of the bed. Tenant #5 had attempted to stand independently while in the apartment. When staff members arrived, Tenant #5 had fallen onto the floor, resulting in a laceration on the bridge of the nose requiring medical evaluation.

Tenant #5 stood independently and ambulated into the bathroom on 3-26-12 at 1:58 p.m. and fell. The report indicated staff responded to the pad alarm on the pager, finding Tenant #5 on the floor in the bathroom. No injuries were noted. The program's alarm response log indicated Tenant #5 pushed the pendant to summon assistance at 1:52 p.m. and it took staff members three minutes and 57 seconds to respond. The response log had no record of the pad alarm activation between 11:40 a.m. and 3:15 p.m. on 3-26-12.

During interview, the Manager reported there had been a death in Tenant #5's family recently and maybe family had been visiting on that day therefore the alarm had not been placed. The monitors found no evidence of this occurring. Tenant #5 stood independently while in the program's common living room area following an activity on 3-27-12 11:00 a.m. while unattended. Tenant #5 fell, resulting in abrasions to the forehead and knee. The report did not indicate whether the pad alarm had been placed or whether the alarm sounded. During monitor interview, the Manager reported staff members do not place the pad alarm under Tenant #5 when in the common living room or dining room areas as staff members are usually present to observe tenants and felt it a dignity issue to allow other tenants to observe Tenant #5 using the pad alarm.

Tenant #5 stood independently while in his/her room, causing the pad alarm to activate at 6:37 p.m. on 4-8-12. Staff members responded and reset the pad alarm at 6:45 p.m., an eight minute delay. The report indicated that staff members found Tenant #5 on the floor in the apartment, tangled up in the walker. Tenant #5 had a scrape on his/her arm and no further injuries.

Tenant #5 pulled the bathroom emergency cord on 4-12-12 at 3:45 p.m. Staff members responded, finding Tenant #5 on the floor in the bathroom. Tenant #5 reported he/she attempted to toilet independently and fell over backwards, resulting in no injuries. The alarm response log had no data showing the pad alarm had been activated between 2:21 p.m. and 4:45 p.m. on 4-12-12. During interview, Staff #4, CNA, reported she had responded to Tenant #5's apartment when he/she pulled the bathroom cord on 4-12-12 at 3:45 p.m. Staff #4 reported the pad alarm was lying on Tenant #5's bed and she had seen Tenant #5 sitting in the chair shortly before the fall.

During interview, Tenant #5 told the monitors that staff members take too long to respond to call light requests "so I just get up" independently if it takes too long.

The alarm response logs for the pad alarm from 3-1-12 through 4-15-12 documented 40 response times exceeding five minutes. The documented response times ranged from 5 to 14 minutes.

The monitors interviewed multiple direct care workers, finding the following:

Staff #1, CNA, reported finding Tenant #2 and Tenant #4 in their rooms either on the bed or in the chair unattended without having the pad alarm placed underneath them occasionally.

Staff #4, CNA, reported finding Tenant #2 and Tenant #4 in their rooms either on the bed or in the chair unattended without having the pad alarm placed underneath them about 50 percent of the time, mostly noting these occurrences when beginning her shift.

Staff # 5, CNA, reported finding Tenant #2 and Tenant #4 in their rooms either on the bed or in the chair unattended without having the pad alarm placed underneath them "all the time."

Staff #6, CMA, reported finding multiple tenants who no longer reside at the program in their rooms either on the bed or in a chair unattended without having the pad alarm placed underneath them on occasion. Staff #6 was unable to recall the names of the tenants at the time of the interview.

Tenants #1, #2, #3, #4, and #5 required physical assistance with ambulation and transfers. The program initiated the use of the personnel pad alarms for Tenants #1, #2, #3, #4, and #5 in an attempt to decrease falls and assure tenant safety. Staff members did not always place the personal pad alarms for Tenants #2, #3 and #5 as service planned. Tenants #2, #3 and #4 experienced falls when the personal pad alarms had not been placed as service planned or the pad alarms failed to activate according to alarm response logs. Staff did not always respond timely when a personal pad alarm was activated for Tenants #1, #2, #3, #4, and #5. Tenant #5 reported staff members did not timely respond to call light requests on many occasions.

- Regulatory Insufficiency: All tenants have the right to receive care, treatment and services which are adequate and appropriate. (IAC r. 481-67.3(2))

- Regulatory Insufficiency: All tenants have the right to receive from the manager and staff of the program a reasonable response to all requests. (IAC r. 481-67.3(5))

During the course of the investigation, the monitors identified the following:

B. Service Plans

- Monitoring Observation:

  During interview, the Manager reported Tenants #1, #2 and #5 used a personal pad alarm system when in each individual's apartment unattended but did not require the use of the alarms when out in the common areas of the program as staff members are always present in those areas.

  During interview, Staff #1, #3 and #6 reported they work frequently with Tenants #1, #2 and #5. All report personal pad alarms are placed for these tenants only when they are in their own apartments and never when they are in common areas of the program.

  Tenant #1's service plan, dated 2-7-12, directed staff members to place a personal pad alarm underneath Tenant #1 at all times when in a chair as Tenant #1 required stand by assistance with all transfers due to impaired vision and attempts to transfer and ambulate independently when unattended. During interview, the Manager reported the service plan should have identified the need for the pad alarm to be used only when Tenant #1 was unattended in the apartment.

  Tenant #2's service plan, dated 2-7-12, directed staff members to place a personal pad underneath Tenant #2 at all times when in bed or in a chair as Tenant #2 required assistance of a staff member with all transfers and escort to and from meals/activities for safety reasons.

During interview, the Manager reported the service plan should have identified the need for a pad alarm to be used only when Tenant #2 was unattended in the apartment. Tenant #2 experienced a fall when unattended in the common dining room area on 3-2-12.

Tenant #5's service plan, dated 3-8-12, directed staff members to place a personal pad underneath Tenant #5 at all times when in bed or in a chair as Tenant #5 required assistance of a staff member with all transfers and stand by assistance with ambulation for safety reasons and Tenant #5 often forgot to use the pendant to summon staff member assistance. During interview, the Manager reported the service plan should have identified the need for a pad alarm to be used only when Tenant #5 was unattended in the apartment. However; the monitors identified Tenant #5 experienced a fall while unattended in the common living room area on 3-27-12.

Program staff did not place alarms underneath tenants when out in the common areas of the program. Tenants #2 and #5 experienced falls while unattended out in the common areas of the program. Service plans for Tenants #1, #3 and #5 did not accurately reflect each tenant's individualized needs.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22 (1) and 69.22 (2) and shall be designed to meet the specific needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26 (1))