IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 39600-I

July 18, 2012

Ms. Debby Cooper, Director
Bickford Cottage of Marshalltown
101 Newcastle Road
Marshalltown, IA 50158

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

Dear Ms. Cooper:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of July 12, 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 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:

Debby Cooper, Director
Bickford Cottage Assisted Living
101 Newcastle Road
Marshalltown, Iowa 50158

Complaint/Incident Intake #:

39600-I

Date of Complaint/Incident Investigation:

July 12, 2012

Monitor(s):

Maribeth Freland 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:	32
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	35
TOTAL census of Assisted Living Program	35

Program History – The Program did not receive any regulatory insufficiencies during this certification period.

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

Tenant Rights

Complaint/Incident Allegation: The program reported Staff #2 alleged Staff #1 treated Tenant #1 unkindly while providing personal care assistance and alleged Staff #1 did not reposition Tenant #2 when found to be lying sideways in bed.

- Monitoring Observation: Tenant #1, a 93 year old, was admitted to the program on 10-12-01 with diagnoses of: Multi-infarct Dementia; Depression: History of Strokes; Osteoarthritis and Chronic Urinary Tract Infections. Tenant #1 scored a 6 on the Global Deterioration Scale (GDS) completed on 6/20/12, indicating severe cognitive decline. Tenant #1 moved to a long term care facility on 6-26-12.

  Tenant #1's service plan, updated on 6/20/12, indicated Tenant #1 required the assistance of one staff member for eating, bathing, grooming and dressing. The service plan indicated Tenant #1 was incontinent of bowel and bladder, requiring the use of incontinence products. Staff members assisted Tenant #1 with changing of his/her incontinence product and cleansing before and after each meal and at bedtime. The service plan indicated Tenant #1 required the assistance of one staff member to transfer and ambulate while using a walker and gait belt for safety.

  Progress notes documented Tenant #1 previously required staff member assistance to transfer into and out of a wheel chair. Once in the wheel chair Tenant #1 self propelled around the program in the wheelchair. Tenant #1 began running the wheelchair into other tenants in late May 2012 through early June 2012. None of the other tenants were injured during any of these incidents but the program feared for the safety of other tenants.

On 6-5-12, after meeting with Tenant #1's legal representative, a decision was made to take the wheel chair out of Tenant #1's room and the program initiated staff member assistance to be provided to Tenant #1 with all transfers and ambulation. Staff members were to use a gait belt and a walker for safety during the transfer and ambulation assistance. A personal pad alarm was to be placed under Tenant #1's buttocks whenever he/she was sitting in a chair or lying in bed. The personal pad alarm sounded audibly with changes in pressure on the pad, thereby, alerting staff members to Tenant #1's potential attempts at initiating transfers or ambulation without staff member supervision. Tenant #1 began showing increased agitation and combativeness with staff member attempts at assistance with personal care tasks following these changes.

On 6-8-12 and 6-10-12, Tenant #1 required use of Seroquel, an anti-anxiety medication, due to increased agitation and combativeness. On 6-12-12, program Administration met with Tenant #1's legal representative to discuss Tenant #1's alternative placement due to his/her poor response to the removal of his/her wheel chair.

On 6-15-12 during the night shift, Tenant #1 attempted to transfer from his/her bed into a chair without staff member assistance. Tenant #1 did not fall. Later in the day, Staff #3, certified medication aide (CMA), noted two large discolored areas/bruising to Tenant #1's left wrist and forearm area.

On 6-17-12, Staff #2, certified nurse aide (CNA) assisted Tenant #1 with toileting needs. Staff #2 noted Tenant #1 sitting a table in the common dining room. Tenant #1 had a gait belt on that had previously been applied. Staff #1 did not adjust Tenant #1's gait belt as she believed the gait belt tension to be appropriate. Staff #2 assisted Tenant #1 into a standing position and used the gait belt and a walker to ambulate from the dining room to Tenant #1's apartment. While ambulating down the hallway, Staff #4, CMA, saw the two and felt that due to Tenant #1's recent agitation and combativeness a second staff member may be needed to complete Tenant #1's incontinence care safely. Staff #4 asked Staff #1, a registered nurse (RN) used by the program on an as needed basis, to assist Staff #2 with Tenant #1's care. Staff #1 joined Tenant #1 and Staff #2 in the hallway. The RN felt Tenant #1 was faltering and feared he/she may fall. The RN reported she felt the gait belt was looser than she would have liked so the RN pulled up on the back of Tenant #1's pants to hold Tenant #1 upright as all three ambulated toward Tenant #1's apartment.

Tenant #1 was ambulated safely to his/her bathroom. During incontinence care, Tenant #1 became combative, slapping at Staff #2. The RN secured both of Tenant #1's hands by placing Tenant #1's hands together in a praying position and the RN placed her hands around each of Tenant #1's wrists to keep him/her from slapping Staff #2. Staff #2 cleansed Tenant #1's perinea and replaced his/her incontinence product. The gait belt was tightened and both staff members assisted Tenant #1 to his/her bed to rest. The RN believed Tenant #1 was still not steady while ambulating and believed he/she may fall. The RN reported she used the gait belt to lift Tenant #1 up onto the side of the bed to avoid the fall. Tenant #1 did not receive any injuries. Staff #3, who had previously noted bruising to Tenant #1's left wrist and forearm verified no new bruising was noted to Tenant #1's wrists when assessed in conjunction with the Program RN on 6-18-12.

Tenant #1's agitation and combativeness did not improve. Tenant #1's legal representative and the program administration determined Tenant #1 could not remain at the program self propelling his/her wheel chair therefore the decision was made to move Tenant #1 to a long term care facility on 6-26-12.

Tenant #2, an 88 year old, was admitted to the program on 1-5-04 with diagnoses of: Dementia; Depression; Glaucoma; Poor Appetite and Lung Cancer. Tenant #2 scored a 5 on the GDS completed on 6-25-12, indicating moderately severe cognitive decline. Tenant #2 was a hospice patient.

Tenant #2's service plan, dated 6-25-12, indicated Tenant #2 was independent with eating, hygiene, toileting, transfers and ambulation. On 6-17-12, Staff #4, CMA, noted Tenant #2 lying sideways on his/her bed in what appeared to be an uncomfortable position. Staff #4 asked Tenant #2 if she could assist Tenant #2 into a more comfortable position. Tenant #2 said "no, no, no" and then refused to come out for supper. Staff #4 complied with Tenant #2's wish to remain positioned as lying. Staff #1 witnessed this interaction between Tenant #2 and Staff #4.

Approximately 30 to 45 minutes later, Staff #2, CNA, and Staff #1, RN, entered Tenant #2's room, noting Tenant #2 was lying in what appeared to be an uncomfortable position. Staff #2 attempted to reposition Tenant #2. Tenant #2 refused to move. Staff #1 told Staff #2 it was okay for Tenant #2 to remain lying in this position and then suggested instead to place a pillow under Tenant #2's head.

During interview, Staff #4 reported Tenant #2 frequently sat on the side of his/her bed. When wanting to rest, Tenant #2 would lie back positioning him/herself in a sideways position. Tenant #2 most often refused repositioning.

- Regulatory Insufficiency: None noted.