IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 39755-I

August 20, 2012

Ms. Emily Elmendorf, Administrator
Bickford Cottage Assisted Living
3500 Lower W. Branch Road
Iowa City, IA 52245

RE: Final Complaint/Incident Investigation Report, Bickford Cottage Iowa City, 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 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS

Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Emily Elmendorf. Administrator
Bickford Cottage Assisted Living
3500 Lower W. Branch Road
Iowa City, IA 52245

Complaint/Incident Intake #: 39755-I

Date of Complaint/Incident Investigation:

July 11, 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.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	27
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	33
TOTAL census of Assisted Living Program	33

Program History – The Incident Investigation of November 9 and 14, 2011 resulted in a regulatory insufficiency in the area of: Service Plan.

The Complaint and Incident Investigation of August 2 and 3, 2011 resulted in a $5,000 civil penalty and regulatory insufficiencies in the following areas: Tenant Documents, Service Plan, Nurse Review, Dementia Education, and Tenant Rights.

The Complaint Investigation of May 25 and 26, 2011, resulted in a $4,000.00 civil penalty and regulatory insufficiencies in the following areas: Evaluation of Tenants, Service Plan, Nurse Review, Tenant Documents and Rights.

The Complaint Investigation of January 3 and 4, 2011, resulted in a civil penalty of $1,000.00 and regulatory insufficiencies in the areas of: Evaluation, Service Plan, Nurse Review and Policy and Procedure.

The October 11 and 12, 2010 Recertification, Complaint and Incident Investigation resulted in a civil penalty of $4,000.00 and regulatory insufficiencies in the areas of: Evaluation of Tenants, Service Plan, Food Service, Staffing and Record Checks.

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

A. Staffing

Complaint/Incident Allegation: The program reported Tenant #1 fell in his/her room on 7-4-12. Tenant #1 reported another tenant came in his/her room and pushed him/her down. Staff responding to Tenant #1's call for assistance found Tenant #1 lying on the floor with a pillow under his/her head. Tenant #1 was sent to a hospital emergency room and was admitted for a Right Tibia Fracture.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1, a 93 year old, was admitted on 2-26-10 and had diagnoses of: History of Cerebro Vascular Accident (CVA), Hypertension (HTN), Congestive Heart Failure (CHF), Hyperlipidemia, Coronary Artery Disease (CAD), Osteoporosis, Pacemaker Placement, Lumbar Stenosis and Edema. Tenant #1 was admitted to hospice on 11-18-11 with an admitting diagnosis of Failure to Thrive. A cognitive evaluation was completed on

6-15-12 staged Tenant #1 at three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline. A service plan of 6-15-12 indicated Tenant #1 needed assistance with activities of daily living (ADLs), used a wheeled walker but ambulated independently.

An incident report and progress notes of 7-4-12, at approximate 3:20 p.m., indicated Tenant #1 called for staff assistance. Upon arrival, staff found Tenant #1 on the floor in front of a chair, with a pillow under his/her head. Tenant #1 reported he/she heard two knocks on the door. Upon opening the door, Tenant #2 entered and said he/she was going to kill Tenant #1. Tenant #2 then knocked Tenant #1 to the ground.

A licensed practical nurse (LPN), Staff #1 evaluated Tenant #1 and Tenant #1 denied any dizziness or headache, but did complain of back pain. Staff LPN #1 reported to the Program nurse, Tenant #1 appeared to be okay, but was complaining of back pain. Staff LPN#1 administered pain medication with positive results noted. Progress notes of the same date but separate entry indicated staff escorted Tenant #1 for supper. Tenant #1 complained of right knee pain. Upon return to Tenant #1's apartment, Tenant #1 was able to walk from the bathroom to the chair independently without pain. Family members spoke to staff about the incident and voiced concern about Tenant #1's safety. Tenant #1 complained of back and knee pain. Progress notes of the same date, but separate entry indicated Tenant #1's family reported Tenant #1 had a swollen left eye, a rug burn on the right leg and shin and a rug burn on the buttocks. Progress notes of the same date, but separate entry indicated Staff LPN #1evaluated Tenant #1 and noted Tenant #1 complained of pain when moving his/her leg.

Another family member of Tenant #1 called Staff LPN #1 to Tenant #1's apartment to discuss the incident that occurred earlier in the day. Tenant #1 had complained of pain throughout his/her body and had knee, back and hip pain. Tenant #1 reported he/she was punched in the face by another tenant, instead of being pushed down. Tenant #1 became confused and was unable to describe the sequence of events.

Progress notes of 7-5-12 indicated Tenant #1's family member requested staff assist Tenant #1 with toileting. Staff assisted Tenant #1 to the restroom and Tenant #1 complained of right knee pain. Upon visual inspection Tenant #1's right knee cap was swollen and tender to touch. Tenant #1's family member reported he/she would call Tenant #1's physician to make an appointment. Staff asked Tenant #1 if he/she needed to be seen by a physician immediately. Tenant #1 reported he/she wanted to see a physician immediately. Staff called for an ambulance and Tenant #1 was transported to a hospital emergency room for evaluation and treatment. Tenant #1 was admitted to the hospital with a diagnosis of fracture to the tibial plateau. As of this date, Tenant #1 had not returned to the Program.

Tenant #2, an 82 year old, was admitted on 7-3-12 and had diagnoses of: Dementia, a History of Falls, Chronic Anxiety and Osteoporosis. Tenant #2 scored four out of 30 on a mini mental status examination on 7-3-12, which indicated severe cognitive decline. Functional and health evaluations were completed on 7-3-12. The Program determined Tenant #2 was appropriate to be admitted to their Program. Program notes indicated Tenant #2 had chronic anxiety and had been prescribed as needed (prn) medication.

A service plan of 7-3-12 indicated Tenant #2 needed assistance with ADLs. The service plan indicated Tenant #2 became agitated at times, if told to do something he/she didn't want to do. Incident reports and progress notes of 7-4-12 indicated three separate incidents that occurred between 3:00 p.m. and 3:30 p.m. involving physical and verbal aggression from Tenant #2 toward Tenant's #1, #3 and #4.

An incident report of 7-4-12, at approximately 3:00 p.m. staff reported Tenant #4's family member reported Tenant #2 had entered Tenant #4's apartment and stated "they are trying to kill me, and they are going to kill you too," and then left the apartment

At approximately 3:00 p.m. – 3:09 p.m. Staff heard Tenant #3 call for help and found Tenant #3 sitting in a wheelchair and Tenant #2 was holding Tenant #3's wrists. Staff separated Tenant #2 from Tenant #3 and Tenant #2 tried to hit staff. Tenant #2 took a purse and pendant belonging to Tenant #3 and swung the purse at staff. Another staff approached Tenant #2, recovered the purse and pendant and returned them to Tenant #3. Staff LPN #1 evaluated Tenant #3 and no apparent injuries were noted. The Program nurse was called and directed staff to give Tenant #2 Seroquel as needed (prn) medication. Upon entering Tenant #2's apartment Tenant #2 asked for a pair of scissors. Staff denied Tenant #2's request and Tenant #2 stated he/she was going to kill staff and began hitting staff. Staff backed away and re-approached Tenant #2 and offered the medication again, which Tenant #2 took.

At approximately 3:20 p.m. the Program nurse directed Staff LPN #1 to monitor Tenant #2's actions until another staff person could arrive to provide one-on-one monitoring of Tenant #2. At approximately 3:36 p.m., Staff #2 began one-on-one care for Tenant #2. Tenant #2 and staff were sitting in the dining room when Tenant #2 requested a knife. Staff refused Tenant #2's request and Tenant #2 attempted to dump hot chocolate on staff and the kitchen manager. Tenant #2 was escorted back to his/her apartment. The program nurse reported she called the Program at 4:00 p.m. and spoke to staff regarding Tenant #2's status. Staff reported the above incident and directed staff to call for ambulance service to transport Tenant #2 to a hospital emergency room for evaluation.

Progress notes of the same date but separate entry, at approximately 4:20 p.m. Staff #3 saw Tenant #2 walking down a hallway carrying a pair of orange scissors. Tenant #2 asked Staff #3 to cut off his/her watch with the scissors. Staff asked Tenant #2 if she could look at the scissors and Tenant #2 gave the scissors to staff. At 4:35 p.m. an ambulance arrived and transported Tenant #2 to a hospital emergency room for evaluation. Progress notes of the same day, but separate entry, indicated Tenant #2 was admitted to the hospital. As of this date. Tenant #2 had not returned to the Program.

The Program nurse reported at approximately 3:20 p.m. she directed Staff #2 to monitor Tenant #2's actions until another staff person could arrive to provide one-on-one monitoring of Tenant #2. At approximately 3:36 p.m., Staff #2 began one-on-one care for Tenant #2. Progress notes of the same date, at approximately 4:20 p.m. Staff #3 saw Tenant #2 walking down a hallway carrying a pair or orange scissors. Despite having one-on-one monitoring during this time, Tenant #2 was able to obtain a pair of scissors.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))