IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 40814-I

October 5, 2012

Ms. Heidi Fristo, Administrator
Bickford Cottage West Des Moines
5050 Hawthorne Drive
West Des Moines, IA 50265

RE: Final Complaint/Incident Investigation Report – Bickford Cottage West Des Moines, West Des Moines, IA

Dear Ms. Fristo:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of October 3, 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 515/281-7039 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: **Complaint/Incident Intake #:** 40814-I

Heidi Fristo, Administrator
Bickford Cottage Assisted Living
5050 Hawthorne Drive
West Des Moines, IA 50265

Date of Complaint/Incident Investigation:

October 3, 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 Definition	
Number of tenants without cognitive disorder:	33
Number of tenants with cognitive disorder:	17
Total Population of Program at time of on-site	50

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	57

Program History – The program received regulatory insufficiencies in the areas of: Occupancy Agreement, Medications, Food Service and Staffing during the Recertification on site of April 19, 2011. The program received a regulatory insufficiency in the area of Service Plan during the November 28, 2011 Complaint (36861-C) investigation.

A. Tenant Rights

Complaint/Incident Allegation: It was alleged the Program moved a tenant out of his/her apartment, and the tenant was sleeping in the lobby all day. The Director asked staff to take the tenant home to live with them.

- Monitoring Observation: Three tenant files were reviewed. No issues were found regarding Tenants #1 and #2.

  Tenant #3, a 90 year old, was admitted on 5-1-10 and had diagnoses of: Dementia, a History of Urinary Tract Infections and Hypertension. A Global Deterioration Scale was completed on 7-20-12 and staged Tenant #3 at six, which indicated severe cognitive decline.

  Tenant #3 resided in Mary B's, a secured unit of the program. A nurse review of 7-6-12 indicated Tenant #3 had declined functionally and physically. The nurse notified Tenant #3's physician and requested a hospice evaluation. Functional, cognitive and health evaluations were completed and a service plan was updated to reflect the tenant's needed for personal and health related cares. On 7-10-12 a hospice evaluation was completed and Tenant #3 was admitted for hospice care on 7-12-12. The Program completed functional, cognitive and health evaluations on 7-12-12 and a service plan was updated to reflect hospice care.

  Nurse's notes of 7-20-12 indicated Tenant #3 was moved from Mary B's to apartment 112 in the general population at the request of Tenant #3's legal representative, as

Tenant #3's health status deteriorated. The nurse reported Tenant #3 moved to apartment 112 on 9-14-12 to be closer to the nurse's office. She and staff could be more attentive to Tenant #3's needs. The Administrator reported Tenant #3 moved from apartment #112 to apartment #101 the same day, 9-14-12, at approximately 9:30a.m., and moved into apartment #112 at approximately 1:30 p.m. Tenant #3's family made the request to move Tenant #3 to a smaller apartment due to financial concerns. Tenant #3 stayed in the common area until his/her belongings were moved into the new apartment.

Staff #1 was interviewed and reported Tenant #3 was moved closer to where the nurse and staff could be more attentive to Tenant #3's needs. Tenant #3 had dementia and family made the decision to move Tenant #3.

Staff #3 was interviewed and reported Tenant #3 moved from apartment 112 to apartment 101 on the same day. Tenant #3's belongings were placed in the hallway while the new apartment (apt. #101) was prepared. Tenant #3's move from one apartment to another happened the same day, was done at the request of family and was done in order for staff and the nurse to be more attentive to Tenant #3's needs.

- Regulatory Insufficiency: None noted.