IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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Complaint/Incident Intake #: 40752-C

October 18, 2012

Ms. Kris Trotter, Administrator
Bickford Cottage Cedar Falls
5101 University Avenue
Cedar Falls, IA 50613

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

Dear Ms. Trotter:

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 515/281-7039 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:

Bickford Assisted Living
Kris Trotter, Administrator
5101 University Ave.
Cedar Falls, IA 50613

Complaint/Incident Intake #:

#40752-C

Date of Complaint/Incident Investigation:

September 18, and 26, 2012

Monitor(s):

Joyce Kix, RN
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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	30
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	37
TOTAL census of Assisted Living Program	37

Program History – The program received regulatory insufficiencies in the areas of Dementia Specific Education and Record Checks during the Jan. 27, 2011 Recertification and Incident (32166-I) Investigation.

Complaint/Incident Investigation – The Complaint/Incident investigators made the observations detailed in the following areas:

A. Tenant Rights

Complaint/Incident Allegation: It was alleged the program allowed incompetent tenants to have intimate relationships with other tenants.

- Monitoring Observation: Tenant #3, a 73 year old, was admitted on 5-8-12 with diagnoses of: Hypertension (HTN), History of Cerebral Vascular Accident, Insomnia, Obesity, Dementia, and Memory Loss. Tenant #3 scored 26 of 30 questions correctly on the Mini Mental Status Exam (MMSE) completed 6-7-12 which indicated normal cognitive function. The Resident Information form indicated Tenant#3 had a designated power of attorney which had not been activated.

  Tenant #4, a 72 year old, was admitted on 10-8-11 with diagnoses of: Hydrocephalus with a shunt, Chronic Urinary Tract Infections, Insomnia, Dementia, Anxiety, HTN, Osteopenia and Obesity. Tenant #4 scored 3 on the Global Deterioration Scale (GDS), completed 5-23-12, which indicated mild cognitive decline. Tenant#3 had a designated power of attorney which had not been activated at the time of the incident.

  An incident report, dated 5-15-12, documented that Staff #1, certified nursing assistant (CNA), entered Tenant #3's locked room to retrieve laundry. Staff #1 had knocked and did not receive a response so she entered using her key. Staff #1 observed Tenant #3 and Tenant #4 in an intimate situation. Staff #1 left the room and informed Staff #2, CNA, who called the program Registered Nurse (RN). The RN instructed staff to separate the tenants as soon as possible. The incident report

documented that it was apparent to both Staff #1 and #2 that the intimate actions occurring were of mutual consent; however, Staff #2 ordered them to stop what they were doing and get dressed. Staff #1 escorted Tenant #4 back to his/her room. Both Tenant #3 and #4 were informed that their actions were inappropriate and should never happen again. The RN requested that both tenants visit only in public and not in individual apartments. The families of both tenants and their individual physicians were notified.

The program intervened inappropriately during a private intimate relationship between two competent tenants violating their dignity and right to autonomy.

Tenant #4's cognitive status declined progressively, resulting in a GDS score of 4 on 8-3-12. Tenant #4 no longer participated in an intimate relationship with Tenant #3. During the on-site visit, the monitors observed Tenant #4 and Tenant #5 holding hands and talking on a couch in the common living room area.

Tenant #5, a 76 year old, was admitted to the program on 5-30-12 with diagnoses of: Hypertension, Ventricular Tachycardia, History of Stroke and Paget's Disease. Tenant #5 answered 28 of 30 questions correctly on the program's cognitive assessment; thereby, showing no cognitive decline. During interview, Tenant #5 reported holding hands and pecking on the cheek on occasion with Tenant #4. Tenant #5 reported being aware of Tenant #4's cognitive status and reported no sexual contact had or will ever occur between the two.

During interview, Staff #1, #2, #3 and #4 reported they had not observed any inappropriate behaviors between Tenant #4 and Tenant #5 or any other tenant since Tenant #4's cognitive decline. Tenant #4's DPOA had been activated since the cognitive decline. During interview, Tenant #4's legal representative reported visiting often. The DPOA reported never witnessing any inappropriate sexual contact involving Tenant #4 with Tenant #5 or any other tenant since Tenant #4's cognitive decline. Tenant #4's DPOA feels Tenant #4 has consented to the hand holding with Tenant #5. The DPOA reported sitting with both tenants on multiple occasions and believed Tenant #4 was happy and the relationship appeared to be comforting and healthy.

- Regulatory Insufficiency: All tenants have the right to be treated with consideration, respect, and have full recognition of personal dignity and autonomy. (IAC r. 481-67.3(1))

B. Medications

Complaint/Incident Allegation: It was alleged that a tenant was routinely refusing medications.

- Monitoring Observation: Clinical records and medication administration records (MAR) were reviewed for five tenants. Medications were documented as given per physician's orders for four of the tenants. The MAR for Tenant #4 documented refusal of medication occurred on 7-16 and 20-12. Refusal of medications was also documented on 8-18, 29, 30 and 31-2012. The September MAR documented Tenant

#4 refused to take medications on 9-1, 2, 3, 4, 5, 7, 9 and 10-12. The clinical record contained documented of physician notification on 9-5-12 regarding the tenant's refusal of medication and communication with the physician again on 9-10-12 when the physician stated he did not want to change anything at that time. The program documented refusals and notified the physician and family appropriately regarding refusals to take medication.

- Regulatory Insufficiency: None noted.

During the course of the investigation the following information was identified.

C. Staffing

- Monitoring Observation: An incident report dated 5-15-12 documented that Staff #1, CNA, entered Tenant #3's locked room to retrieve laundry. Staff #1 had knocked and did not receive a response so she entered using her key. Staff #1 observed Tenant #3 and Tenant #4 in an intimate situation. Staff #1 left the room and informed Staff #2, CNA, who called the program Registered Nurse (RN). The RN instructed staff to separate the tenants as soon as possible. The incident report documented that it was apparent to both Staff #1 and #2 that the intimate actions occurring were of mutual consent; however, Staff #2 ordered them to stop what they were doing and get dressed. Staff #1 escorted Tenant #4 back to his/her room. Both Tenant #3 and #4 were informed that their actions were inappropriate and should never happen again. The RN requested that both tenants visit only in public and not in individual apartments.

  The RN later spoke with the corporate personnel who informed her that a mutually consenting intimate relationship was appropriate for cognitively well adults and in the future, staff members should not intervene. Training was provided for all staff regarding Resident Rights on 6-8-12 which included sexual activity among tenants. During interviews, Staff #1 and #2, the RN and the Manager stated they were not aware how to handle the situation and admitted they had intervened inappropriately. Staff members were not trained appropriately regarding resident rights.

- 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))

D. Evaluation

Complaint/Incident Allegation: It was alleged that a tenant had lost a lot of weight.

- Monitoring Observation: Clinical records for five tenants were reviewed. Tenant #1, #2 and #3 did not have weight loss. Tenant #5 had a history of weight loss prior to admission to the program. Tenant #5's service plan indicated the program initiated the Nutrition Intervention Protocol (NIP) upon Tenant #5's admission. The clinical record for Tenant #4 documented a weight of 171 pounds on 4-30-12 and a current weight of 137 pounds. Tenant #4, experienced a decrease in cognitive abilities from a GDS of 3 to a GDS of 4, a urinary tract infection and medical evaluation and change

in a cerebral shunt during this timeframe which potentially contributed to weight loss. The program notified the physician and initiated the NIP plan and plan to offer coffee to encourage Tenant #4 to attend meals in the dining room. NIP is a protocol for tenants at high risk for weight loss which includes supplemental calories. The program identified Tenant #4 and Tenant #5's weight loss and responded appropriately.

- Regulatory Insufficiency: None noted.

E. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged that a tenant exceeded the level of care that could be provided by an assisted living program.

- Monitoring Observation: The clinical records for five tenants were reviewed. Tenant #1, #2, #3, #4, and #5 did not exceed the level of care determined appropriate for assisted living. During interview, Staff #1, #2, #3, and #4 reported no tenants exceeded the level of care.

- Regulatory Insufficiency: None noted.