IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 41326-I

November 26, 2012

Ms. Jennifer Westfall, Director
Bickford Cottage Ames
2418 Kent Avenue
Ames, IA 50010

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

Dear Ms. Westfall:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of November 13, 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 #: 41326-I**

Jennifer Westfall, Director
Bickford Cottage Ames
2418 Kent Avenue
Ames, IA 50010

Date of Complaint/Incident Investigation:

November 13, 2012

Monitor(s):

Lori Miner, RN BSN

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:	26
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	33
TOTAL census of Assisted Living Program	33

Program History – The program received regulatory insufficiencies in the areas of Criteria for Admission and Retention and Policy and Procedure during the July 10 and 11, 2012, Complaint Investigation (39840-C). The program received a regulatory insufficiency in the area of Tenant Rights during the September 12 and 13, 2012 Complaint Investigation (40421-C).

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

A. Evaluations

Complaint/Incident Allegation: The program reported a tenant fell and fractured a hip.

- Monitoring Observation: Tenant #1, a 94 year-old, was admitted on 1-6-06 and had diagnoses of: Cerebrovascular Accident, Hypertension (HTN), Transient Ischemic Attack, Moderate Dementia after Stroke, Diabetes Mellitus, Peripheral Neuropathy, Gastroesophageal Reflux Disease, and Agitation. Tenant #1 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. On 9-8-12, Tenant #1 leaned forward in a wheelchair and slid out onto buttocks. There was no documentation of immediate injury noted, and Tenant #1 had no complaints of discomfort on 9-10-12. On 9-12-12, Tenant #1 complained of ankle pain, was noted to have ankle swelling, and the ankle was tender to touch. Tenant #1 also had difficulty with weight bearing. Tenant #1 was seen by a physician and diagnosed with a right ankle fracture on 9-13-12. Evaluations were completed on 9-13-12 and Tenant #1 required assist of one and a walker for transfers, and escorts to meals. Night checks were to be done two to three times a night. Tenant #1 was to use a walking boot with ambulation. Evaluations were again completed on 9-27-12 following a course of antibiotic for fever and cough. Tenant #1 continued to require assist with transfers, assist with toileting, a frequent night checks.

  An incident report dated 10-13-12 and timed 2:45 a.m. revealed Tenant #1 was found on the floor of the apartment. The walker was seen in the hallway. Tenant #1 had no apparent injuries and was assisted to bed and observed through the night without any further incidents. At 9:00 a.m., Tenant #1 complained of pain with movement.

Tenant #1 was transported to the hospital and was diagnosed with a hip fracture. The program reported Tenant #1 would not be returning.

Staff #1, Certified Medication Aide (CMA), was interviewed and stated Tenant #1 did not require assistance with transfers before the walking boot was applied. Tenant #1 used the call light and would ask for it if a staff member did not give it to him/her. Tenant #1 was checked every two hours, and before and after meals. Tenant #1 spent time in the common living area during the day, and was checked on if not in the common area.

Staff #2, Certified Nursing Assistant, stated persons in need of assistance were in the common living area during the day and checked frequently. Staff #2 stated staff members knew tenants routines and knew when tenants needed cares.

Staff #3 CMA, who was working the night Tenant #1 was found on the floor, stated she went to answer a call light and saw Tenant #1's walker in the hallway. Staff #3 went to check on Tenant #1 and found Tenant #1 on the floor. Staff #3 stated it was unusual to see the walker in the hallway. Staff #3 stated Tenant #1 never got out of bed independently. Tenant #1 was on a nightly toileting schedule, and Tenant #1 was routinely checked. Staff #3 reported she was frequently in the hallway responding to other call lights, and checked on Tenant #1 at least every two hours. Staff #3 reported she knew Tenant #1's routine. The call light was reported to be on Tenant #1's bed rail.

In an interview with the director, she stated a document she provided to the department was in error. The document stated Tenant #1 was unable to call for assistance with transfers. The director reported Tenant #1 was able to call for transfers. The director stated if a tenant was unable to call for assistance, the service plan would identify staff response, usually night checks. The nurse stated Tenant #1 was able to use a call light.

The service plan for Tenant #1, dated 9-27-12 identified when Tenant #1 was on night checks and was to be taken to the bathroom two to three times during the night. Tenant #1 required assist of one with transfers and used a walker to get to the bathroom in the apartment. Tenant #1 was to use a walking boot with ambulation following an ankle fracture. Tenant #1 was encouraged to walk short distances.

The service plan effective at the time of a fall resulting in a hip fracture identified Tenant #1 required assistance with transfers. Three staff members indicated Tenant #1 was checked regularly including during the night. Staff members reported knowing tenant routines and being able to anticipate needs. A night shift worker, Staff #3 reported it was unusual for Tenant #1 to be out of bed without assistance.

The program reported the incident to the department in a timely manner. An incident report documented the event.

Tenant #2, a 93 year-old, was admitted on 3-21-07 and had diagnoses of: Hypothyroidism, Osteoporosis, Zenker's Diverticulum, Dementia, Anemia, Osteoarthritis, and Agitation. Tenant #2 was staged at five on the GDS which indicated moderately severe cognitive decline. An incident report dated 9-10-12 and

timed 6:45 p.m. documented a staff member heard Tenant #2 calling for help. Tenant #2 was found on the floor of the apartment. Tenant #2 complained of pain in the right elbow but was able to move it. Tenant #2 requested arthritis rub. At the time of the incident, Tenant #2 used a wheelchair to pedal around, and would walk occasionally. Staff walked with Tenant #2 or returned Tenant #2 to the wheelchair. Tenant #2 was independent with toileting. A nurse review completed on 9-11-12 indicated Tenant #2 had no pain and no visible signs of injury. On 9-17-12, progress notes documented Tenant #2 complained of right arm pain and the right elbow was larger than the left. Tenant #2 was unable to move the arm. A telephone call was made to the nurse and the legal representative. Staff was given instructions to offer "as needed" pain medication and to put the arm in a sling. Tenant #2 refused. On 9-18-12, the nurse spoke with the legal representative who indicated Tenant #2 became anxious about going to see the physician, and the legal representative did not want Tenant #2 taken to the physician's office, according to the nurse. The nurse contacted the physician who ordered a stronger pain medication. Tenant #2 was eventually seen by a physician on 9-24-12 and Tenant #2 was diagnosed with an elbow fracture. A sling was to be worn as tolerated and a pain medication was ordered. Evaluations were completed on 9-24-12 and the service plan was updated. No falls were documented after 9-10-12.

Tenant #3, a 96 year-old, was admitted on 4-29-09 and had diagnoses of: HTN, Edema, Arthritis, Osteoporosis, and Hypothyroidism. Tenant #3 was staged at three on the GDS which indicated mild cognitive decline. An incident report dated 9-10-12 and timed 8:30 a.m. indicated a staff member walked into the apartment and found Tenant #3 on the floor. Tenant #3 reported trying to pick up something of the floor and falling off the bed. Staff #1 reported Tenant #3 used a call button, but not at the time of this incident. At the time of the incident, Tenant #3 ambulated independently with a walker and was on a toileting schedule. Tenant #3 was taken to the hospital by family. Tenant #3 was admitted for a heart condition. According to the nurse, Tenant #3 was admitted to skilled care after hospitalization and sustained a spontaneous hip fracture while in skilled care. Tenant #3 was discharged from the program.

Tenant #4, an 84 year-old, was admitted on 7-7-08 and had diagnoses of: Hypothyroidism, Depression, Irritable Bowel Syndrome, and Vascular Dementia. Tenant #4 was staged at five on the GDS which indicated moderately severe cognitive decline. An incident report dated 10-26-12 and timed 4:10 p.m. indicated a staff member entered the apartment and found Tenant #4 lying on the floor. Staff #2 reported Tenant #4 was unable to reach the call button. Tenant #4 complained of back, hip, and knee pain. Tenant #4 was transferred to the hospital and diagnosed with a hip fracture. At the time of the incident, Tenant #4 ambulated with a walker and staff was to assist when a hip was bothering Tenant #4. Staff members were to assist with transfers if needed. Tenant #4 was on a toileting schedule. Tenant #4 has not returned to the program.

Tenants were found in their apartments. None required assistance with ambulation while in their apartments. The program had a system in place, the service plan, for identifying the needs of tenants unable to use the call button.

- Regulatory Insufficiency: None noted.