IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 41775-C

February 11, 2013

Ms. Sarah Akers, Director
Bickford Cottage Marion
1100 Linden Drive
Marion, IA 52302

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

Dear Ms. Akers:

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: **Complaint/Incident Intake #:** 41775-C

Sarah Akers, Director
Bickford Cottage Marion
1100 Linden Drive
Marion, IA 52302

Date of Complaint/Incident Investigation:

January 8 & 9, 2013

Monitor(s):

Stephanie Cummins, MA

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:	21
Number of tenants with cognitive disorder:	10
Total Population of Program at time of on-site	31
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	38

Program History – The Program received a regulatory insufficiency in the area of staffing during the October 18, 2011 Recertification visit. During the February 27 and 28, 2012 Complaint Investigation (37713-C) the program received a regulatory insufficiency in the area of medications. During the May 24, 2012 Incident Investigation (39084-I) the program received a regulatory insufficiency in the area of staffing.

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

A. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged a tenant exceeded the level of care.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed. Per review of the tenant files, staff interviews, an interview with the RN Coordinator and the Director, Tenant #2 exceeded the level of care.

  Tenant #2, a 90 year old, was admitted on 9-17-04 and diagnoses included: Dementia, Hypertension, Osteoporosis, Status/Post (S/P) Pacemaker, S/P Cataract Surgery Left Eye, Severe Pain and Syncope. Tenant #2 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #2 resided in the dementia unit. According to Progress Notes dated 11-19-12, Tenant #2 threw a glass at staff at lunch. Staff tried to talk to Tenant #2 and Tenant #2 hit the staff in the breast. Progress Notes dated 12-2-12 indicated Tenant #2 was found in Tenant #2's apartment with feces spread on the kitchen counter. The counter was cleaned and hands were washed. Progress notes dated 12-3-12 indicated Tenant #2 was tearful at times, was incontinent of urine on the apartment floor one time on the shift and refused to let staff take vitals. Progress Notes dated 12-6-12 indicated

Tenant #2 was tearful, speech was word salad and Tenant #2 was unable to verbalize feelings and thoughts. Tenant #2 quickly became angry, had a furrowed brow, swatting staff and others away and walked briskly to Tenant #2's apartment door and slammed the door. Tenant #2 blocked the apartment door at the foot to prevent staff from entering the apartment. Leaving Tenant #2 and re-approaching in 15 minutes was effective at times. According to Progress Notes dated 12-13-12, staff reported Tenant #2 refused a shower and dressing that morning and became angry. Tenant #2 was swatting at staff and grabbed staff's sleeve. Tenant #2 was left alone and re-approached and the shower and shampoo was completed. Tenant #2 was incontinent of urine in the common living room. There were three attempts by staff to encourage Tenant #2 to change clothing and Tenant #2 was resistive. Tenant #2 removed all bed linens two times that day, put the linens on the floor and urinated on the linens. Progress Notes dated 12-26-12 (Nurse Review) indicated Tenant #2 had outbursts where Tenant #2 had thrown dishes from dining room table on the floor, was tearful, angry and joyful without triggers. Tenant #2 had episodes of slamming the apartment door and blocking staff from entering. Tenant #2 had been found with feces in areas of the apartment other than the bathroom. Tenant #2's family and doctor were aware of increasing need for care.

Tenant #2's service plan updated on 12-26-12 reflected a History of Urinary Tract Infections (UTIs), Tenant #2 could become physically resistive quickly and had become aggressive towards staff when clearing dishes from the table. The service plan indicated Tenant #2 urinated on the floor, in trash cans, removed bowel movements from the toilet and hid it in the apartment. The service plan provided interventions related to behaviors and toileting. According to a fax to the doctor on 12-21-12, Tenant #2 had very dark urine and questionable blood was noted on the protective undergarments. A urine analysis and culture and sensitivity if indicated were ordered. Amoxicillin 500 mg by mouth twice daily for seven days was ordered on 12-28-12.

According to an Incident Report on 10-1-12, on two different occasions staff found balled up feces on Tenant #2's counter in the apartment. Staff disposed of the feces and cleaned the counter with disinfectant. According to an Incident Report dated 10-20-12, while staff provided p.m. cares Tenant #2 became very angry, picked up Tenant #2's wet protective undergarments and shoved them in a staff's face, hitting the staff in the mouth and chin.

According to the Staff Communication Log dated 1-2-13 on the day shift, Tenant #2 refused to go to the toilet in the afternoon and five attempts were made. On 1-2-13 on the night shift Tenant #2 refused a shower and toilet four times. On 1-3-13 on the afternoon shift staff tried to shower Tenant #2 and Tenant #2 was very aggressive. On 1-4-13 on the afternoon shift Tenant #2 was very combative when toileting and it took two staff to get Tenant #2 cleaned and ready for bed. The Staff Communication Log dated 1-5-13 on the afternoon shift indicated Tenant #2 was in a bad mood and staff attempted three times with cares, Tenant #2 became very combative and took two staff. On 1-6-13 on the day shift Tenant #2 was in a horrible mood towards the end of the shift, would not let staff in the apartment and would not void. On 1-6-13 on the afternoon shift Tenant #2 was combative with cares, staff attempted three times and it took two staff to complete cares and get Tenant #2 dressed. On 1-7-13 on the night shift Tenant #2 voided on the carpet once.

Staff #1 said at times Tenant #2 would let staff take Tenant #2 to the bathroom and at other times Tenant #2 would smear feces around the apartment including in the kitchen sink, garbage, under the pillow and on the floor. Staff #1 said it varied depending on mood. Staff #1 said Tenant #2 could be aggressive and would lash out, scream, throw things, yell, hit, kick and punch staff. Tenant #2 did not have aggressive behaviors towards other tenants.

Staff #2 said once a shift Tenant #2 was aggressive towards staff. Tenant #2 had thrown things at the table, slapped staff and when toileted yelled and screamed. One day Tenant #2 was aggressive towards another tenant's family and was smacking the family. Tenant #2 did not have behaviors towards other tenants. Tenant #2 was incontinent of stool once a week. Staff #2 said there were feces on the counter top in the kitchen, on the bed, on the bathroom sink and Tenant #2 urinated on the floor.

Staff #3 said if Tenant #2 was very resistant to help, two staff was used if needed due to resistance. Tenant #2 was incontinent of urine every day and would toilet on the floor. Feces had been found on the floor in Tenant #2's apartment, living area and bathroom. Tenant #2 was resistant and combative just with cares.

Staff #4 said Tenant #2 had periods of behavior issues and it was not consistent. It happened approximately two to three times per week but not for a long period of time. Staff #4 said at times Tenant #2 would go to the bathroom independently and occasionally had an accident. Staff #4 said Tenant #2 had a UTI and received medication. Staff #4 said Tenant #2's participation depended on mood and she did not have much trouble.

The RN Coordinator said it was difficult to determine the triggers for Tenant #2's behaviors. Tenant #2 did use the toilet but would also line up feces on the sink in the bathroom, kitchen and feces was found around Tenant #2's mouth. The issues had not occurred in the common areas. Staff cleaned Tenant #2 up and cleaned the apartment. Tenant #2 had pulled down pants and voided on furniture, including the dresser and chair. Family took the furniture out of the apartment. The frequency of the feces issue was once every two weeks and the voiding was daily. Tenant #2's family was spoken to right before the holidays and was told they might need to find a higher level of care. Two facilities declined Tenant #2 as an admission. A 30 day notice was not given.

The Director said the frequency of Tenant #2's aggressive behaviors was once a week and it happened with certain staff. There had not been any harm to tenants. Tenant #2's family had taken out the furniture because the furniture was soiled. Staff disinfected everything and worked hard to make sure there were not any odors. Staff shampooed the carpet and there had not been any complaints about odor from Tenant #2 or the family. The Director said Tenant #2 was getting to the point of exceeding level of care.

The Director indicated on 12-14-12 a meeting was held with a corporate staff and Tenant #2's level of care was discussed and deemed they needed to give the family a 30 day notice. They had previously worked with the family in finding placement and

Tenant #2 had been assessed and declined by two facilities. A meeting was scheduled for 1-21-13 to discuss a 30 day notice.

Per review of tenant files, staff interviews, an interview with the RN Coordinator and the Director, Tenant #2 exceeded the level of care in regards to unmanageable incontinence and behaviors.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: (c) Is dangerous to self or other tenants or staff, including but not limited to a tenant who: Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression; (g) Has unmanageable incontinence on a routine basis despite an individualized toileting program. (IAC r. 481-69.23(1)(c,g))

B. Service Plans

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

  Tenant #3, a 73 year old, was admitted on 6-3-10 and diagnoses included: Bipolar, Osteoarthritis, Hypothyroidism and Chest Pain. Tenant #3 was staged at four on the GDS on 4-4-12, which indicated moderate cognitive decline. According to the Medication Administration Record, Tenant #3 was not to leave the Program unless accompanied by another responsible adult for safety reasons. The service plan did not reflect the informational order. According to a fax to the doctor, Tenant #3 had an increase in lethargy and had a nine pound weight loss in the past 30 days. The service plan did not reflect the weight loss and increased lethargy. According to Progress Notes dated 1-7-13, Tenant #3's family was going to contact an outside agency to provide one to one companion care from 8:00 a.m. to 8:00 p.m. The service plan did not reflect the one to one companion. The service plan did not reflect the identified needs of Tenant #3.

  Tenant #4, a 77 year old was admitted on 4-9-12 and diagnoses included: UTI and Pneumonia. Tenant #4 was staged at a three to a four on the GDS, which indicated mild to moderate cognitive decline. According to Progress Notes dated 12-5-12, Tenant #4 was found laying supine on the floor and blood was observed on the wall and floor. Tenant #4's head and neck were stabilized and 911 was called. The posterior head was bleeding. Tenant #4 was transferred to an emergency room by ambulance. Tenant #4 returned to the Program on 12-5-12 and was wearing head dressing. Blood was oozing and the dressing was changed. Progress Notes dated 12-5-12 to 12-10-12 reflected dressing changes and complaints of pain or soreness to the head and neck. According to a Physician Visit form dated 12-11-12, the staples were completely scabbed over and were unable to be removed without significant pain to Tenant #4. The following was ordered: to work on removing scabbed area from the scalp with warm soapy water and gentle abrasion and to clean area on posterior left scalp then okay to remove staples. Hydrocodone-Acetaminophen 5-325 mg one by mouth 30 minutes before working on scalp (one time dose) was also ordered. The

service plan did not reflect the dressing change and removal of the scabbed area. The service plan did not reflect the identified needs of the Tenant #4.

Tenant files indicated service plans did not reflect the identified needs of the tenants.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

C. Structural Requirements

Complaint/Incident Allegation: It was alleged there were odors in the building.

- Monitoring Observation: The building was toured as part of the investigation. The building appeared clean and without odors in the common areas. One tenant apartment had what appeared to be an odor; however, the odor did not permeate into the common areas.

  Staff #1 said Tenant #2's apartment had an odor; however, there were no odors in the hallway. Staff cleaned it up immediately.

  Staff #2 said there were no concerns with housekeeping or odors. Tenant #2's apartment had an odor; however, the carpet was shampooed and staff tried to keep it aired out.

  Staff #3 said Tenant #2's apartment tended to have an odor and the carpet was shampooed.

  Staff #4 did not have any concerns with housekeeping or odors in the building.

  The Director indicated there had not been complaints from tenants or families regarding housekeeping or odors in the building. In regards to Tenant #2's apartment, she said Tenant #2's family had taken out the furniture because the furniture was soiled. Staff disinfected everything and worked hard to make sure there were not any odors. Staff shampooed the carpet and there had not been any complaints about odor from Tenant #2 or the family.

  Per observation, staff interviews and an interview with the Director there were no concerns related to odors in the building.

- Regulatory Insufficiency: None noted.