IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 42905-I

April 1, 2013

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

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

Dear Ms. Akers:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of March 19, 2013, 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 #:** 42905-I

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

Date of Complaint/Incident Investigation:

March 19, 2013

Monitor(s):

Margaret Kaltefleiter, RN MS

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.

General Population Program	
Number of tenants without cognitive disorder:	20
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	29

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	6
TOTAL census of Assisted Living Program	35

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. During the January 8 and 9, 2013 Complaint Investigation (41775-C), the Program received regulatory insufficiencies in the areas of Criteria for Admission and Retention and Service Plan.

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

A. Other

Complaint/Incident Allegation: The Program reported Tenant #1 fell in an unlocked laundry room. Tenant #1 had a lump on the right leg and favored that leg. Tenant #1 was sent out for evaluation the next day and had suffered a fractured hip.

- Monitoring Observation:

  Tenant #1, an 86 year old, was admitted on 4-5-06 and diagnoses included: Congestive Heart Failure, Dementia, Edema of Lower Extremities, Gastro Esophageal Reflux Disease, Hypertension, Hyperlipidemia, Hypothyroidism, Right Shoulder Pain, and Renal Insufficiency. Tenant #1 was staged at a six on the Global Deterioration Scale which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit.

  According to an Incident Report dated 2-10-13 at 6:15 p.m. Staff #1 was working in the kitchen in the unit when she noticed Tenant #1 was not sitting on the couch. Staff

#1 got up to find Tenant #1 lying on the floor of the unit's laundry room, feet facing out towards door, lying on back. The Certified Medication Aide (CMA) was notified immediately. Tenant #1 was looked over for signs and symptoms of pain/discomfort/injuries. Hips and arms rotated without any problems. Tenant #1 was able to ambulate, and favored right leg. Tenant #1 had a golf ball-sized lump on the right leg below the hip joint and above the knee on the outer aspect of the leg with no bruising noted. Vitals were taken. The physician and nurse were notified and a call was made to a family member.

Incident Reports for Tenant #1 were also provided dated 1-19-13, (found sitting on the floor beside bed, Active Range of Motion (AROM) completed, no complaints or concerns, no visible injuries); 2-5-13 (Tenant #1 observed on floor next to couch, AROM without pain or discomfort, able to ambulate without any problems); and 2-7-13 (Tenant #1 found sitting on bottom next to side of bed, AROM with complaint of pain to left arm, a small skin tear and fresh bruising noted).

According to the Progress Notes dated 2-10-13 at 6:55 p.m. Tenant #1 was discovered lying on the floor of the laundry room, partially on the right side with legs outstretched, facing the door. Tenant #1 was partially on back and favoring the right leg. Hips and arms rotated without any problems and Tenant #1 was able to ambulate. A golf ball-sized lump was present on the outer aspect of the right leg and no redness or bruising was noted. Ice was applied on and off when Tenant #1 allowed. Blood pressure was 120/82, Temperature 97.5, Pulse 66 and Respirations 20. The physician and RN were notified. A call to a family member was made. On 2-11-13 at 6:45 a.m. Tenant #1 was transported via ambulance to a hospital due to extreme pain in the right hip. Prior to being sent to the hospital, Tenant #1 was unable to bear weight on right leg. The on-call nurse was contacted at approximately 5:20 a.m. and the CMA on duty reported a golf ball-sized lump was found on the right hip area. Tenant #1 was alert when the ambulance arrived and was able to convey pain.

According to the Progress Notes dated 2-11-13 at 1:30 p.m. a call was received from the hospital surgery center indicating Tenant #1 had a fractured hip and would be going into surgery.

According to Staff #1, after supper she was cleaning the kitchen and didn't see Tenant #1 on the couch. She found Tenant #1 on the laundry room floor with feet facing towards the doorway. The door was closed. Tenant #1 was lying back on both elbows. Tenant #1 sighed and giggled when found. Staff #1 checked Tenant #1's head and didn't find anything. Staff #1 called Staff #2, LPN, and waited for Staff #2 to obtain the vitals. Staffs #1 and #2 got Tenant #1 up and walked the tenant to a chair. Tenant #1 sat there awhile and then staff walked Tenant #1 to a recliner. No bumps or bruises were noted but Tenant #1 favored the right leg. Staff #1 tried to keep ice on Tenant #1's hip but Tenant #1 didn't want the ice. Around 9:30 p.m. Tenant #1 walked from the recliner, wiggling feet and laughing. Tenant #1 avoided answering any questions regarding pain. Staff #1 sat on the couch with Tenant #1. At 10:00 p.m. Tenant #1 got ready for bed, stood but was wobbly so Staff #1 used a wheelchair to take Tenant #1 back to the living room. Tenant #1 was able to walk and bear weight.

According to Staff #2, Staff #1 called and said Tenant #1 had fallen. When she arrived, Tenant #1 was leaning towards the right side and back. Staff #2 said she took Tenant #1's vitals. Tenant #1 was rubbing hip area of leg and couldn't understand commands to move the leg so Staff #2 rotated the leg. Tenant #1 would grab between knee and hip. the spot felt hard like a muscle. Staff #2 tried to ask questions in regards to any pain but Tenant #1 did not answer. Tenant #1 was walked to a chair and favored the right leg so Tenant #1 sat in a chair. The on-call nurse was called and she advised staff to put ice on the area and keep an eye on it. Information was faxed to the physician and a message was left for a family member. Tenant #1 kept moving the ice away so Staff #2 told Staff #1 to let her know if it got worse. She checked Tenant #1 a few more times during her shift. It didn't get worse but she could tell the leg was sore. Tenant #1 would hold leg when walking but had no pain or complaints when sitting.

According to a written statement provided by Staff #3, when she came on shift at 11:00 p.m. she received report that Tenant #1 had fallen. Staff #1 indicated that Tenant #1 had fallen in the laundry room and had a faint bruise to right hip; otherwise Tenant #1 was ambulating fine. Tenant #1 was in the living room recliner. At 11:30 p.m. Tenant #1 was assisted to the restroom. Tenant #1 stood with assistance and proceeded to ambulate toward Tenant #1's room. Tenant #1 limped, seemed to favor the right side but walked at a steady pace. One apartment away from Tenant #1's apartment. Tenant #1 began to grimace and slowed walk to labored single steps. Tenant #1 continued to walk to room and was assisted to the restroom and then to bed. Tenant #1 was too close to the edge of the bed and unable to move away from the edge. Tenant #1 immediately stood and pivoted to a wheelchair and was taken back to the recliner in the living room. The CMA was notified of Tenant #1's discomfort. At 5:00 a.m. the CMA wanted to witness Tenant #1's transfer. Tenant #1 expressed pain through moaning and facial grimacing to even stand and refused to take a step. The CMA called the on-call nurse and then informed staff that Tenant #1 would be going to the hospital. At 6:15 a.m. Tenant #1 left with paramedics.

The On-Call Nurse indicated she received a call from staff that Tenant #1 had fallen, denied pain and had movement of all extremities. Staff reported "a bump" above the knee, swollen, not bruised. Vitals were taken and family made aware. She told staff to call back with any changes in the skin, ROM or behavior. At 5:30 a.m., staff called and reported Tenant #1 was unable to bear weight and in pain. She told staff to send Tenant #1 for evaluation immediately.

According to the Registered Nurse Coordinator (RNC), Tenant #1 had a fall on a Sunday. She was notified on Monday morning between 7:00 and 7:30 a.m., was told Tenant #1 was being sent to the emergency room. She asked what had happened. Tenant #1 had no pain while lying flat but upon weight bearing there was pain. Tenant #1 received scheduled Tylenol for arthritis and did not verbalize any pain. Upon waking Tenant #1 had more pain. She stayed in touch with the family and Tenant #1 went to surgery for a hip fracture about 3:00 p.m.

Staff #1, Staff #2, the RNC and the Director stated Tenant #1 was independent in ambulation and did not use any assistive devices. The RNC stated Tenant #1 needed verbal cueing to go from a sitting to standing position.

Staff #1 said the situation was handled appropriately as they did the best they could do at that time. Staff #2 said she felt the situation was handled appropriately; if Tenant #1 had been in more pain she would have sent Tenant #1 sooner. The RNC stated the situation was handled appropriately.

The Program provided a written document dated 2-15-13 from Tenant #1's Power of Attorney indicating Tenant #1 was moving to a long-term care facility. Tenant #1 did not return to the Program after hospitalization.

The Program completed an incident report and reported the incident to the Department.

Review of Tenant #1's file, staff interviews, review of incident reports and review of policies was completed.
exits.

- Regulatory Insufficiency: None noted.