IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 42162-I

April 9, 2013

Ms. Lynne Mynatt, Director
Bickford Cottage Burlington
3301 Sterling Drive
Burlington, IA 52601

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

Dear Ms. Mynatt:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of March 19 and 27, 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 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
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 #:** 42162-I

Lynne Mynatt, Director
Bickford Cottage Burlington
3301 Sterling Drive
Burlington, IA 52601

Date of Complaint/Incident Investigation:

March 19 and 27, 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.

General Population Program	
Number of tenants without cognitive disorder:	36
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	38
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	6
TOTAL census of Assisted Living Program	44

Program History – The program received a regulatory insufficiency in the area of Dementia Specific Education during the July 10, 2012 Recertification and Incident Investigation (39757-I).

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

A. Other

Complaint/Incident Allegation: The Program reported a tenant fell, had a bump on the back of the head, was bleeding in the left ear and vomited. The tenant went to the Emergency Room (ER) and later died there.

- Monitoring Observation: Three tenant files were reviewed.

  Tenant #1, a 90 year old, was admitted on 1-28-12 and diagnoses included: Hypertension (HTN) and History of Deep Vein Thrombosis (DVT). Tenant #1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. Tenant #1 resided in the dementia unit. According to a census summary, Tenant #1 was discharged on 1-2-13.

  According to an Incident Report, on 12-31-12 at 8:00 p.m. Tenant #1 was found on the floor with a bump on the back of the head and had bleeding in the left ear. Vitals were taken and were as follows: blood pressure was 130/70, temperature was 97.2, pulse was 80 and respirations were 20. Range of motion (ROM) was done and Tenant #1 was stood up and sat in a chair. Tenant #1 vomited and had some blood from the nose. Tenant #1's family came and took Tenant #1 to the hospital.

The Nurse documented on the Incident Report, that she received a phone call at 8:00 p.m. and Tenant #1 was found on the floor. Tenant #1 had no complaints of pain, had a small amount of blood was in the left ear. Tenant #1 was taken to the ER by family. Tenant #1 died at a hospital at 1:00 a.m.

According to hospital information, Tenant #1 had non-displaced or depressed fractures of the left temporal and occipital bones with a large amount of extra-axial blood and a small amount of pneumocephalus with a midline shift to the right by 1.2 cm. The longitudinal fracture of the left temporal bone extended into the sphenoid sinus.

Tenant #1's file was reviewed. Progress Notes dated 11-23-12 indicated Tenant #1 was admitted to a hospital for a small blood clot. Tenant #1 returned to the Program on 11-28-12. The discharge diagnoses included: Acute DVT, HTN, Dementia and Urinary Tract Infection. Discharge medications included Warfarin Sodium/Coumadin 6 milligrams (mg) tablet by mouth daily. Discharge instructions indicated a Prothrombin Time/International Normalized Ratio (INR) was scheduled for 11-30-12. The PT/INR was 2.05 on 11-30-12. The doctor ordered no changes in the Coumadin dose and to recheck in one week. The PT/INR was 2.47 on 12-7-12. The doctor ordered no changes in the Coumadin dose and to recheck in one month. According to hospital information, Tenant #1's PT/INR was 3.54 on 12-31-12 at 8:47 p.m.

Tenant #1 had a physician's order for Warfarin (Coumadin) 6 mg tablet, take one tablet by mouth every day. The December 2012 Medication Administration Record, indicated on 12-31-12 the 8:00 p.m. dose of Warfarin (Coumadin) was documented as administered.

An order was received dated 11-29-12 for occupational therapy (OT) and physical therapy (PT) to evaluate and treat. Therapy was started on 12-3-12 and was discontinued on 12-13-12 with therapy goals met.

Evaluations and a service plan were completed on 11-28-12, post hospitalization. The service plan reflected Tenant #1 had been started on Coumadin and staff was to watch for excessive bruising, nose bleeds and alert the Nurse. The service plan also reflected Tenant #1 had orders for PT/OT for gait training and safety. The service plan indicated Tenant #1 used a walker for balance and mobility. Tenant #1 was shaky at times and needed assistance with the walker.

Staff #1 had a written statement and was interviewed. On 12-31-12 she was in with another tenant, heard a noise, went out to check and found Tenant #1 on the floor. Staff #1 called Staff #2 to come to the dementia unit. Tenant #1 was checked over. Tenant #1's family was called and Tenant #1's family came and took Tenant #1 to the ER. She said Tenant #1 did not have Tenant #1's walker. Staff #1 said Tenant #1 was sent to the hospital in less than 30 minutes. She said staff responded appropriately and there was enough staff at the time of incident.

Staff #2 had a written statement and was interviewed. On 12-31-12 at 8:00 p.m. Staff #1 called and told Staff #3. Tenant #1 was on the floor. Staff #2 called the Nurse and told her Tenant #1 was on the floor. Staff #1 was with another tenant. Tenant #1 had

blood coming out of the left ear. Tenant #1 could move extremities. vitals were taken and Tenant #1 did not complain of pain. Staff #3 used a flashlight to look in the ear. She called Tenant #1's family right after calling the Nurse. When staff stood Tenant #1 up and sat Tenant #1 into a chair Tenant #1 vomited and blood came from the nose. Tenant #1 talked to staff and said Tenant #1 was not in pain. Staff #2 said Tenant #1's eyes were clear. there was no facial drooping and Tenant #1's tongue was checked. When Tenant #1's family arrived the family said maybe they should call the ambulance or was it quicker if family took Tenant #1. Staff offered to help get Tenant #1 into the car and Tenant #1 talked to them. Tenant #1's family called and said Tenant #1 had a brain bleed and they decided to keep Tenant #1 there and Morphine and Ativan were given to keep Tenant #1 comfortable. The hospital called at 12:45 a.m. and said Tenant #1 had just died. The Nurse was notified. She said about a half hour before the incident Tenant #1 had received the scheduled dose of Coumadin. She said the Nurse was notified right away and Tenant #1's family arrived in 10 minutes

Staff #3 had a typed statement. They responded to call from Staff #1 in the dementia that Tenant #1 had fallen and was bleeding from the ear. Staff #3 summoned the medication aide. Staff #2. Upon arrival Staff #3 got on the floor and spoke to Tenant #1. Tenant #1 was not in any pain. Staff #3 noticed blood coming from the left ear. She used a flashlight and saw blood pooling inside the ear. Tenant #1's family was contacted and elected to take Tenant #1 to the ER

The Nurse had a typed statement and was also interviewed. She received a phone call from Staff #2 at approximately 8:00 p.m. regarding Tenant #1. Tenant #1 had been found on the floor in the living room of the dementia unit. ROM was completed and Tenant #1 did not feel injured. Staff noticed a small amount of blood in the left ear and a bump on the back of the head. Tenant #1 was placed in the chair and vomited one time. Tenant #1's family took Tenant #1 to the ER for evaluation. Family chose to take Tenant #1 to the hospital in a personal car. At approximately 10:00 p.m. Staff #2 called again and said Tenant #1's family had called from the ER and stated Tenant #1 had brain bleed. The ER doctor said Tenant #1 could be sent to another hospital to stop the bleeding or Tenant #1 could stay at the hospital and pass. If Tenant #1 did not go to the other hospital, Tenant #1 would not be expected to live more than 24 hours. Tenant #1's family decided to allow Tenant #1 to die peacefully. The doctor said the brain bleed might have been caused from the fall or Tenant #1 might have had a stroke and then fell. The doctor was unsure. At approximately 1:00 a.m. on 1-1-13 hospital staff called and stated Tenant #1 had died. Staff notified the Nurse four times regarding the incident, after the incident occurred, when the incident appeared more serious, when she was told it was a brain bleed and when Tenant #1 died. An autopsy was not completed. The Nurse was notified right away and Tenant #1 was taken to the hospital within 15 to 20 minutes. The Nurse said Tenant #1 was not one to get up on his/her own and staff had to encourage Tenant #1 to go. She said staff handled the situation appropriately and there was enough staff at the time of the incident. She said staff followed appropriate protocols and did what they should have done

According to a Fall Investigation document, Tenant #1 had no other falls recently and no changes in medications, mobility or mental status. Tenant #1 did not have any signs of infection and did not have any lab work with abnormal values or changes in

blood sugars. The Fall Investigation did not identify any factors that contributed to the fall

According to incident reports, the most recent fall prior to the incident, occurred on 9-12-12

A fax was sent to Tenant #1's doctor on 12-31-12 regarding the incident. No new physician orders were received.

Staff #1, #2 and #3 had delegations regarding falls, vital signs and falls involving head injury.

According to the 24 Hour Supervision policy, 24 hour supervision was provided by certified caregivers on each shift, seven days a week. The caregivers were awake and on duty and monitored tenants as indicated in the service plans.

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

- Regulatory Insufficiency: None noted.