IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 44624-I
44610-C
44563-I

August 1, 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 July 23 & 24, 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:

Lynne Mynatt, Director
Bickford Cottage of Burlington
3301 Sterling Drive
Burlington, Iowa 52601

Complaint/Incident Intake #:

44624-I
44610-C
44563-I

Date of Complaint/Incident Investigation:

July 23 and 24, 2013

Monitor(s):

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.

General Population Program	
Number of tenants without cognitive disorder:	40
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	42

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	48

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. Tenant Rights

Complaint/Incident Allegation: 44563-I- The program reported a tenant made allegations that a staff member had been seen hugging a cognitively impaired tenant who also resided at the program. The tenant reporting the allegations suspected sexual undertones.

- Monitoring Observation: The program Director reported Tenant #2, a cognitively intact tenant living at the program in the general population area, alleged suspected sexual inappropriateness occurring to his/her spouse, Tenant #1, by Staff #8, certified nursing assistant (CNA).

  Tenant #2, a 97 year old, was admitted to the program on 3-4-13 with diagnoses of: Chronic Renal Failure; Atrial Fibrillation; Coronary Artery Disease and Chronic Urinary Tract Infections. Tenant #2 answered all but three questions correctly on the Mini Mental Status Examination (MMSE) completed on 5-22-13, indicating no cognitive impairment. Tenant #2 resided in the program's general population area with his/her spouse, Tenant #1. Tenant #2 required staff member assistance with bathing and medication administration.

  Tenant #1, a 94 year old, was admitted to the program on 3-4-13 with diagnoses of: Dementia; Anxiety; Hypertension and Malaise/Fatigue. Tenant #1 scored a 3 on the Global Deterioration Scale (GDS) completed on 6-20-13, indicating mild cognitive decline.

Tenant #1 resided in the program's general population area with his/her spouse, Tenant #2. Tenant #1 required staff member assistance with bathing, grooming, dressing and medication administration.

During interview, Tenant #2 reported Staff #8, CNA, was "always telling Tenant #1 he/she was beautiful", was always looking at Tenant #1 when he/she showered and was always touching Tenant #1 "and I know what he/she is after." Tenant #2 reported observing Staff #8 hugging Tenant #1 on multiple occasions. Tenant #2 denied seeing Staff #8 kissing Tenant #1 "but I'm sure it's happening." Tenant #2 denied seeing Staff #8 touching Tenant #1's private body parts "but I know it's happening". Tenant #2 verified Tenant #1 required staff member assistance with showers, grooming and dressing. Tenant #2 verified Staff #8 often helped with showering and dressing Tenant #1.

During interview, Tenant #1 denied being afraid of any of the direct care workers, male and female. Tenant #1 reported all direct care workers were kind and took good care of him/her. Tenant #1 denied being touched in a sexual manner by any of the direct care workers. Tenant #1 denied being hurt in any physical or sexual way while living at the program.

During interview, Staff #1, #2, #4, #5, #6 and #7, all direct care workers, reported never witnessing behaviors by Staff #8 as making them feel uncomfortable or questioning of sexual inappropriateness. All six of the staff members reported Staff #8 was a caring individual who went above and beyond to assist each tenant. All six of the staff members reported Staff #8 often said nice, complimentary things to male and female tenants, including Tenant #1, when seeing them and would at times give both male and female tenants, including Tenant #1, hugs across the shoulders or touch the top of their hands when talking to them. All six staff members denied witnessing Staff #8 kissing tenants or touching them in a sexual manner. All staff members reported Tenant #1 had a tendency to want to lie in bed all day so took much coaxing to get up for meals. All of the staff members reported giving compliments and talking to in a loving manner worked well to get Tenant #1 out of bed.

During interview, Tenants #5, #6, #7, #8 and #9, all cognitively intact tenants residing in the program's general population area, denied being afraid of any direct care workers, male and female. All five tenants reported all of the direct care workers were kind and took good care of them. All five tenants denied witnessing or experiencing any inappropriate sexual contact from staff members to tenants. All five tenants reported staff members, especially Staff #8, went out of their way to make them feel loved and have a purpose.

During interview, Staff #8 denied ever kissing or touching the private body parts of any male or female tenants residing at the program, including Tenant #1. Tenant #1 reportedly refused to get up for meals. Staff #8 indicated if he talked nicely to Tenant #1 and gave compliments to Tenant #1, he/she responded to requests to get up and come to meals in a positive manner. Staff #8 reported he often gave hugs to male and female tenants, including Tenant #1, "to make them feel like they mean something and are loved".

The monitor was unable to substantiate Tenant #2's allegations of inappropriate sexual behaviors. Tenant #2 did not observe Staff #8 kissing or touching Tenant #1's private body parts. Staff members and other tenants residing at the program denied witnessing and/or experiencing any inappropriate sexual contact by Staff #8 or any other staff member.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation: 44624-I - The program reported a cognitively impaired tenant left the building and the program's grounds without staff member knowledge. The tenant fell while unsupervised, resulting in injury requiring emergent medical evaluation. 44610-C- It was alleged a cognitively impaired tenant left the building and the program's grounds without staff knowledge. The tenant fell while unsupervised, resulting in injury requiring emergent medical evaluation.

- Monitoring Observation: The program reported one tenant eloped from the program without staff knowledge of the tenant's absence. (Tenant #3) The monitor reviewed Tenant #3's clinical record and conducted associated interviews.

  The programs entire building was alarmed with two alarm systems. The first system included alarms on all identified exit doors. All exit doors were locked and alarmed, requiring a code to be input into a pad to disengage the alarm system in order to go in and out of the door without sounding the alarm. Each exit door had an egress bar that when pushed would sound an audible alarm and send a message to a pager carried by each staff member to alert the staff to an attempt at unauthorized exit from the building. If the egress bar is pushed for 15 seconds, the door will automatically open allowing exit from the building. The second alarm system was the Home Free system. The Home Free System included the wearing of a watch that when the watch comes close in proximity to an exit door, the system sends a message to a pager carried by each staff member, identifying the tenant who is close to an exit door. The program used this system for all tenants identified as an elopement risk.

  Tenant #3, a 78 year old was admitted to the program on 2-25-12 with the diagnoses of: Dementia with Memory Loss; Degenerative Joint Disease and Chronic Urinary Tract Infections resulting in confusion. Tenant #3 resided in the program's general population area. Tenant #3 scored a 4 on the Global Deterioration Scale (GDS) completed on 6-6-13 and 7-19-13, indicating moderate cognitive decline.

  According to nurse notes, on 6-17-13 Tenant #3 began exhibiting increased confusion and paranoia. The program registered nurse (RN) notified Tenant #3's physician of his/her changes in behavior. Tenant #3's physician ordered a urinalysis to be obtained. The urinalysis showed positive for bacteria. A culture and sensitivity of the urinalysis was completed and Tenant #3 was treated with an antibiotic that would treat the identified organism.

On 6-24-13 the program RN contacted Tenant #3's physician to report Tenant #3's continued paranoia and increased agitation despite treatment of the urinary tract infection. The physician ordered Risperidal (an antipsychotic medication) to treat Tenant #3's agitation and changed Tenant #3's antibiotic, treating Tenant #3 for 7 additional days with the new antibiotic. On 7-8-13 the program RN again contacted the physician to report Tenant #3's increased paranoia and agitation. The physician determined no medications or changes were required at that time.

On 7-18-13 at approximately 7:00 p.m., Tenant #3 exited the building with a visitor and walked from the building approximately 0.2 miles. Tenant #3 fell in the parking lot of a local bank, resulting in abrasions to the face, shoulders and knees, two broken front teeth and a fractured thumb. A passerby found Tenant #3 and summoned emergency services. The program was notified of a confused person found nearby the program and the program initiated a head count to determine if any tenants were missing. The program found Tenant #3 to be absent from the program and immediately contacted the police department to report the missing tenant. The police verified Tenant #3 had been found and was being treated at the local emergency room. Tenant #3 returned to the program on 7-19-13. The program immediately placed a home free watch on Tenant #3 and initiated having Tenant #3 going to the secured memory care unit after awakening in the morning until bedtime at approximately 8:30 p.m. each evening. Tenant #3 ate all three meals in the memory care unit and participated in activities in the memory care unit but slept in his/her apartment in the general population area of the program each night following the 7-18-13 elopement. On 7-19-13 the program placed a sign at the main entrance on the inside and outside of the building instructing visitors not to allow anyone to exit the building when coming or going as the program housed tenants with dementia.

During interview, the family member of Tenant #4 told the monitor she visited Tenant #4 on 7-18-13 at approximately 6:30 p.m. Tenant #4 had moved into the program the previous day therefore Tenant #4's family member was not familiar with the program. The family member forgot something in the car so she exited the main entrance shortly after her arrival. The family member reported Tenant #3 exited the building when the family member did. The family member did not realize Tenant #3 lived at the program as the tenant was standing, holding a purse, and visiting with another person near the front door.

During interview, Staff #1, #2, #3, #4, #5, #6 and #7, all direct care workers, reported Tenant #3 had not shown any exit seeking behaviors since admission to the program and experienced no elopements from the program prior to 7-19-13. All of the above stated staff members indicated Tenant #3 enjoyed visiting with tenants, staff and visitors near the main entrance of the program, often expressing a wish to go home and telling others he/she planned to go home soon. All of the above stated staff members indicated Tenant #3 often carried a purse and walked around the program.

During interview, the program RN reported when Tenant #3 was admitted to the program, Tenant #3 expressed a wish to go home. The program initiated the use of a home free watch. The watch was connected to the program's alarm system. When Tenant #3 got close to an exit door, the alarm would send a message a pager carried by each staff member alerting staff that Tenant #3 was near an exit door. Tenant #3 wore the watch from February 2012 to October 1, 2012.

During this time Tenant #3 made no exit seeking attempts. The watch was removed with the approval of Tenant #3's legal representative. The RN reported Tenant #3 did not exhibit exit seeking behavior or have any elopements from the program until the incident on 7-19-13.

Tenant #3 did not exhibit any exit seeking behaviors or have previous elopements prior to the 7-18-13 incident. The program initiated appropriate protocol when notified by the police officers of a potential missing tenant and put appropriate measures into place upon Tenant #3's return to the program following Tenant #3's elopement.

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- Regulatory Insufficiency: None noted.