IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 44882-I

August 22, 2013

Ms. Debby Cooper, Administrator
Bickford Cottage Marshalltown
101 New Castle Road
Marshalltown, IA 50158

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

Dear Ms. Cooper:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of August 15, 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:

Bickford Cottage Marshalltown
Debby Cooper, Administrator
101 New Castle Rd.
Marshalltown, IA 50158

Complaint/Incident Intake #:

44882-I

Date of Complaint/Incident Investigation:

August 15, 2013

Monitor(s):

Joyce Kix, RN
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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	34
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	38
TOTAL census of Assisted Living Program	38

Program History – The program received regulatory insufficiencies in the areas of Medications, Nurse Review, Staffing and Tenant Documents during this certification period.

Complaint/Incident Investigation – The Complaint/Incident investigators made the observations detailed in the following areas:

Staffing

Complaint/Incident Allegation: The program reported a tenant fell, sustained an injury, was sent to the hospital and subsequently died.

- Monitoring Observation: Incident reports for the prior three months were reviewed. Two clinical records of tenants who had fallen were selected for review. No significant injuries were identified for Tenant #2.

  Tenant #1, an 83 year old, was admitted to the program 8-31-12 with diagnoses of Congestive Heart Failure, History of Prostate Cancer, History of Lymphoma, Hypertension, Osteoporosis with History of Compression Fractures. Tenant #1 scored 28 of 30 questions correctly on the Mini Mental Status Examination completed 7-24-13 which indicated mild or no cognitive decline. Tenant #1 signed an Emergency Code Status 8-31-12 which indicated No resuscitation should be attempted. The service plan dated 7-24-13 documented Tenant #1 required only stand-by assist with ambulation using a walker and utilizing a wheelchair for longer distances.

  The clinical record indicated Tenant #1 had been hospitalized 6-2-13 for pain with a diagnosis of compression fracture. The physician ordered a Fentanyl Patch at 25 micrograms and Tenant #1 returned to the program on 6-5-13. Tenant #1 was seen by a physician on 7-3-13 who ordered an increase in Xanax to .5 milligrams (mg) twice a day and add Hydrocodone-APAP 10/325 four times a day with direction to hold for over sedation.

Physical Therapy Discharge note dated 7-5-13 documented Tenant #1 had progressed with ambulatory distance and transfer and the goals were met with independence with transfers from stand to sit, and moderately independent with sit to stand with moderate independence with ambulation with a walker on indoor level services.

Incident reports documented Tenant #1 fell on 6-8, 6-24, and 7-2-13 without serious injury. The incident report dated 7-24-13 documented Tenant #1 fell at 5:50 p.m. Staff #1, Certified Medication Aide (CMA) had walked with Tenant #1 to toilet and the tenant was standing at the sink and lost his/her balance falling into the shower stall and hitting his/her head and upper part of back and neck. Staff #1 assisted Tenant #1 to stand and walk to a chair. The Incident report documented that a family member was notified and a facsimile was sent to the physician. Staff #1 assessed the vital signs as blood pressure 181/103, Temperature 98 degrees, Pulse 114, and respirations 24 at 5:50 p.m. Staff #1 called the Registered Nurse (RN) and initiated Neurological checks every 15 minutes.

According to the Neurological Flow Sheet Tenant #1's blood pressure continued readings at: 6:00- 178/100, 6:15- 166/113, 6:30-161/115, 6:45- 150/111 and 7:00 p.m. 146/80. (According to the Monthly Record of Vitals, Tenant #1's blood pressure was 152/96 in June and 149/91 in July) Neurological checks of level of consciousness, movement, hand grasps, pupil size and reaction remained within normal limits.

Staff #1 said Tenant #1 she saw the tenant falling but could not stop the fall. Tenant #1 reported back and neck pain and denied any chest or abdominal discomfort. A family member arrived at approximately 6:30 p.m. and at that time Tenant #1 and the family member decided they did not want to go to the emergency room. Before she left at 7:00 p.m. Staff #1 said Tenant #1 was crying (usual behavior) and she observed no shortness of breath or chest pain.

Staff #2 arrived at 7:00 p.m. for her shift and received report from Staff #1. During interview, Staff #2 stated that when she completed her first neurological check, Tenant #1 did not complain of pain. At approximately 7:15 p.m. the family member told Staff #2 that Tenant #1 was starting to report left chest pain and having trouble catching his/her breath. After Staff #2 checked Tenant #1 again, the family decided to transport per the family car to the hospital. Staff #2 got another staff member to help transfer Tenant #1 to a wheelchair and then the car. Staff #2 reported Tenant #1 was having discomfort but was breathing fine and not gasping for air at all.

Tenant #1 arrived at the hospital with family via car at 8:02 p.m. The Clinical report from the hospital documented Tenant #1 had mild difficulty breathing at rest and was complaining of some neck pain. Tenant #1 was admitted to the intensive care unit. The Discharge from the hospital documented Tenant #1 was diagnosed by x-ray with a traumatic pneumothorax of the left chest. A chest tube was placed with resolution of the pneumothorax; however, Tenant #1 developed progressive effusion on the left side thought to be due to a probable hemothorax. Tenant #1's condition deteriorated over the next two days and the family did not wish to consider further treatment. Tenant #1 died on at the hospital 7-27-13 at 8:16 a.m.

Tenant #1 was documented as independent with ambulation with stand-by assistance of staff. The program appropriately assessed and treated Tenant #1 according to the family and the tenant's wishes. The program reported the fall and subsequent death to the department within the required time-frame.

- Regulatory Insufficiency: None noted