IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 45281-I

October 23, 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 September 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: **Complaint/Incident Intake #:** 45281-I

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

Date of Complaint/Incident Investigation:

September 23 & 24, 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:	40
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	41

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	7
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: The Program reported Tenant #1's family member reported Staff #1 was rough with Tenant #1 during cares.

- Monitoring Observation: Tenant #1, an 86 year old, was admitted on 9-8-12 and diagnoses included: Muscle Weakness, Urinary Tract Infection, Osteoarthritis, Abnormal Gait, Pain, Hypothyroidism, Anxiety, Depressive Disorder, Hypertension, Ischemic Heart Disease, Cerebrovascular Disease, Gastro Esophageal Reflux Disease, Constipation, Cough, Nausea and Diarrhea. Tenant #1's service plan indicated Tenant #1 had two falls, used a walker and was able to get out of a chair by self. Staff needed to encourage Tenant #1 to go slowly and assist on any day Tenant #1 was feeling weak and needed assistance. Tenant #1 had staff bring Tenant #1 in a wheelchair to most meals because Tenant #1 felt unsteady on feet. Tenant #1 would need routing assistance with toileting. Tenant #1 had been able to go to the toilet by self at times.

  According to an Incident Report dated 8-19-13 at 4:15 p.m., the Nurse received an email from Tenant #1's family member. The family member thought Staff #1 hurt Tenant #1 during transfers. The Nurse forwarded the email to the Director who suspended Staff #1 with further investigation to be done.

According to an email dated 8-19-13 at 4:12 p.m. from Tenant #1's family member, Tenant #1 reported Staff #1 hurt Tenant #1 when helping Tenant #1 get up. Staff #1 would grab hands to pull Tenant #1 up instead of the way all of the others who helped get Tenant #1 up. Tenant #1 told Staff #1 that Staff #1 hurt Tenant #1 and Staff #1 called Tenant #1 a grouch. The family member noticed a bruise on the back of Tenant #1's right hand. A family member indicated Tenant #1 bruised easily and sometimes would just bump hand and it bruised, but this bruise was in the perfect shape of a thumb.

The Director was interviewed and stated she received an email from the Nurse that included an email from Tenant #1's family member indicating Staff #1 didn't transfer Tenant #1 the way the other staff did. She immediately suspended Staff #1. On 8-20-13 at approximately 8:30 a.m. she and the Nurse interviewed Tenant #1. On the same day she interviewed Staff #1 who denied everything. Staff #1 was upset and emotional because she thought she had a friendship with Tenant #1 as they talked about each other's families. The Director asked Staff #1 to show her how she transferred tenants. Staff #1 showed the underarm method. When asked if she ever just used her hands, she said yes, Tenant #1. One scenario was with the lift chair and in that situation she used her hands. Staff #1 was asked if she ever called Tenant #1 a grouch. Staff #1 worked with Staff #2 who was very direct and specific, no nonsense. Staff #1 said the only time she used the word grouch in front of Tenant #1 was when she was referring to Staff #2. The Director interviewed Staff #2 and obtained a written statement. A conference call was held with human resources. No one felt the situation was abuse but Staff #1 needed to be retrained before being allowed back on the floor. Training consisted of transfers, hospitality and sensitivity. A therapy program conducted a one on one training session with Staff #1. Staff #1 was counseled and told to think of what responses would be, to ask how tenants liked things done, to ask preferences and always provide a pleasant, positive response. Staff #1 shadowed another staff for two to three evening shifts to get to know the tenants while awake. Staff #1 returned to the night shift but was not to care for Tenant #1. The Director did not see any bruises on Tenant #1's hands and did not see a finger print bruise. The Director stated Staff #1 was reliable, no complaints had been received from other shifts or co-workers and she was a pleasant and sensitive person. Staff #1 had no previous disciplinary action.

The Nurse was interviewed and stated she received an email from Tenant #1's family member that she forwarded to the Director. She said the family member normally visited on the weekends so when she got the email she immediately went to Tenant #1's room and looked at the hands and no bruises were detected. When she and the Director talked with Tenant #1 it sounded like roughness and she questioned if it was a training issue. Tenant #1 didn't like the comment regarding being a grouch. Staff #1 was counseled immediately and an investigation was opened. Staff #1 was suspended and the Department was notified. A phone conference was held with corporate and a decision was made that it was a training issue. A therapy company trained Staff #1, she was reinstated and shadowed other staff. The Nurse followed up with Tenant #1 more than once and Tenant #1 was happy with Staff #1 who was doing a much better job. At no time did the Nurse suspect abuse but also kept an open mind.

An interview was conducted with Staff #1. She said on the night of the situation she got Tenant #1 out of bed. Tenant #1 tipped backwards and Staff #1 would first put hand behind the back and turn Tenant #1 to the side and then put feet down and it was easier to stand up by pulling the hands. When Tenant #1 tipped backwards she caught Tenant #1 who said "Ouch." Staff #1 asked if Tenant #1 was okay. Tenant #1 didn't say anything. She assisted Tenant #1 to the bathroom and back to bed without Tenant #1 making any comment. Staff #1 was not aware of any problem until she was called by the Director to come to the office and was told there was an investigation and she would be off work until everything was cleared. Staff #1 provided a written statement and had to take a class on proper lifting and more orientation to know the other tenants. She was trained on the evening shift. She stated she did not call Tenant #1 a grouch. She called her coworker, Staff #2, a grouch because Staff #2 was a grouch. Staff #1 stated she did not hurt Tenant #1 intentionally.

Tenant #1 was interviewed by the monitor and stated Staff #1 would grab Tenant #1 by the hands and pull Tenant #1. Tenant #1 said Tenant #1 had many sore spots so it hurt. Tenant #1 broke Tenant #1's shoulder prior to moving to the Program and since then the left arm was very weak and sore. Staff #1 was tough and rough. One morning Staff #1 said "You're an old grouch this morning." Tenant #1 admitted not waking up happy as Tenant #1 liked to wake up slowly and Tenant #1 always told a family member not to talk to Tenant #1 before noon. Tenant #1 said Tenant #1 didn't think Staff #1 was hurting Tenant #1 on purpose. Tenant #1 said Staff #1 had retraining and now would say she didn't want to hurt Tenant #1 and took care of Tenant #1 very nicely. Staff #1 would ask "Does what I'm doing hurt you?" Staff #1 was very soothing and gentle now. Most staff was so sweet, once in a while transfers might hurt but it was always accidental. Tenant #1 said Tenant #1's skin was tender and it didn't take much for Tenant #1 to bruise. Tenant #1's left shoulder, arm and hand were tender. Tenant #1 also had a stroke that affected Tenant #1's left side. Tenant #1 wore a brace on left ankle due to weakness and falls, thus it was easier to walk with the brace. Tenant #1 had no concerns about anyone who provided cares, including Staff #1.

A written statement from Staff #2 indicated Tenant #1 turned on light and Staff #1 was busy so Staff #2 answered the light. She took Tenant #1 to the bathroom and was assisting back to bed when Staff #1 came in and said she would finish. Staff #1 put Tenant #1's feet into bed and Staff #2 told Staff #1 she had to take shoes off, socks off, put socks in shoes, put shoes on the stand at the foot of the bed and close the bathroom door. Staff #1 said, "Boy, you're a grouch." Staff #2 took it as Staff #1 talking to her as she was telling Staff #1 what to do.

Staff #3 stated Tenant #1 could walk and get up alone and would call for assistance if Tenant #1 needed anything. Tenant #1 didn't complain. Staff #3 had not been given any special instructions regarding how to transfer Tenant #1. The process Staff #3 used to transfer Tenant #1 was to put her arm into Tenant #1's arm as Tenant #1 pretty much got up and out of the wheelchair on Tenant #1's own.

According to a Counseling Form dated 8-28-13, the Program had a tenant complaint that Staff #1 was rough and hurt Tenant #1 almost every time Staff #1 transferred Tenant #1. Tenant #1 also noted that Staff #1 called Tenant #1 an old grouch. Follow up indicated transfer training, sensitivity training, and hospitality training. Staff #1 was to ask other staff to care for Tenant #1.

A Program document signed by the Director and Assistant Director indicated hospitality and sensitivity training was completed with Staff #1 on 8-28-13. The topics of additional outside transfer training would need to be completed; sensitivity to elderly feelings and responses, as well as proper responses to typically encountered situations was covered with Staff #1 during this training and counseling session.

A document from the therapy company dated 8-29-13 indicated Staff #1 had completed training for proper transfer techniques, body mechanics and slide board transfer education. Staff #1 demonstrated competence for her position as a certified nurse aide at the Program.

According to the August staff schedule, Staff #1 returned to work on the night shift on 8-31-13.

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

Review of the Program's investigation, incident report, staff interviews, Tenant #1 interview and review of Tenant #1's file was completed. The monitor was not able to determine a preponderance of evidence to substantiate the allegation.

- Regulatory Insufficiency: None noted.