IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 45700-I

October 31, 2013

Ms. Mary Keen, Administrator
Bickford Cottage Urbandale
5919 Sutton Place
Urbandale, IA 50322

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

Dear Ms. Keen:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of October 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 515/281-7039 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 #:** 45700-I

Mary Keen, Administrator
Bickford Cottage Urbandale
5919 Sutton Place
Urbandale, IA 50322

Date of Complaint/Incident Investigation:

October 24, 2013

Monitor(s):

Hal L. Chase, RN BSN MPH
Lori Miner, RN BSN

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:	25
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	27

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	14
Total Population of Program at time of on-site	14
TOTAL census of Assisted Living Program	41

Program History – The program received regulatory insufficiencies in the areas of: Medications, Service Plan and Dementia Specific Education during the Recertification, Complaint (39691-C) and Incident (39501-I) Investigation of July 10 and 11, 2012. During the August 20, 2012 Incident Investigation (40147-I), the program received regulatory insufficiencies in the areas of Policies and Procedures and Structural. The program received regulatory insufficiencies in the areas of Tenant Rights and Staffing during the October 9, 2012 Complaint Investigation (41110-C). During the June 4, 2013 Incident Investigation (43871-I) the program received a regulatory insufficiency in the area of Criteria for Admission and Retention. During the Incident Revisit (43871-IR1), the program received a regulatory insufficiency in the area of Structure.

A. Service Plans

Complaint/Incident Allegation: The Program reported Tenant #1 fell on 9-9-10 and 9-10-13. The fall of 9-9-13 resulted in a skin tear to the right elbow. Tenant #1 was seen by his/her physician on 9-10-13. The Program reported the physician noted no injury and no further treatment was ordered. Tenant #1 returned to the hospital on 9-20-13 for a scheduled body scan. Tenant #1's family member reported Tenant #1 might have sustained a fracture to the right elbow. Tenant #1 was admitted for observation and an orthopedic consultation the following day, 9-21-13. Tenant #1 underwent surgery on 9-25-13 to repair a fracture to Tenant #1's right elbow. Tenant #1's family reported Tenant #1's physician suggested Tenant had evidence of a compression fracture, rib fractures and pelvic fracture, and the date of origin was undetermined.

- Monitoring Observation: Tenant #1, a 77 year old, was admitted on 9-6-13 and had diagnoses of: Dementia, Anemia, Urinary Incontinence, History of Benign Colon Polyps, History of Clostridium Difficile, Shingles, Hypothyroidism, History of a Right Hip Fracture and History of Cataract Surgery. A Mini Mental Status Exam completed on 9-6-13 showed a score of seven out of thirty, which indicated cognitive impairment. Tenant #1 resided in the dementia unit.

Functional and health evaluations of 9-6-13 indicated Tenant #1 had a History of a Right Hip Fracture and received physical therapy prior to admission and while residing at the Program. Tenant #1 required assistance with activities of daily living (ADLs) including one staff assist with transfers and ambulation, stand by assist to and from meals and activities, toileting, dressing and grooming.

The service plan of 9-6-13, supported by evaluations, established interventions related to assistance with ADLs. Tenant #1 used a walker and was able to ambulate short distances and used a wheelchair which he/she could self - propel. Staff was to reassure Tenant #1 that family knew he/she resided at the Program and staff were to reorient Tenant #1 several times daily. The service plan identified an outside provider for physical therapy.

An incident report of 9-9-13 indicated staff heard Tenant #1 call for help. Staff found Tenant #1 on the floor lying on his/her side. A skin tear was seen on Tenant #1's elbow. Staff asked Tenant #1 if he/she had fallen and Tenant #1 reported he/she didn't know. Progress notes of 9-9-13 indicated staff notified the nurse of Tenant #1's fall. A nurse review was completed and indicated Tenant #1's family was notified of the possible fall. Tenant #1's family member reported he/she would come to the Program and visit with Tenant #1 and Tenant #1 had an appointment the following day (9-10-13) with his/her physician.

An incident report of 9-10-13 indicated staff was completing rounds and found Tenant #1 lying on the floor on his/her right side, outside of the bathroom. Progress notes of 9-10-13 indicated staff notified the nurse of Tenant #1's fall. Progress notes of the same date, but separate entry indicated Tenant #1 was taken by family to a scheduled physician appointment.

Progress notes of 9-11-13 indicated the Program requested clarification of a physician order of 9-11-13 and notified the physician of a redness to Tenant #1's bottom and requested a cushion for Tenant #1's wheelchair.

A nurse review of 9-11-13 indicated Tenant #1 had not complained of increased or new pain related to the falls of 9-9-13 and 9-10-13. Bed and chair alarm placement was implemented and staff was to check on Tenant #1 between 4:00 a.m. and 6:30 a.m., as Tenant #1 had "typically been an early riser."

Functional and health evaluations were completed on 9-11-13. A cognitive evaluation of the same date, indicated a Global Deterioration Scale (GDS) of four, which indicated moderate cognitive decline. A service plan of 9-11-13 included additional interventions related to a change in cognitive status, nutritional supplements, the use of bed and chair alarms and safety checks.

On 9-16-13 the physician ordered a specific cream to be used on Tenant #1's bottom four times daily and as needed (prn). Evaluations were completed on 9-16-13 and a service plan was updated on 9-16-13 which included interventions related to treatment of redness on Tenant #1's bottom and the placement of a cushion on Tenant #1's wheelchair seat.

Progress notes of 9-20-13 indicated Tenant #1's family notified the Program Tenant #1 was admitted to the hospital after a physician's visit. A consultative report of 9-20-13 indicated Tenant #1 was seen by a new physician. A bone scan indicated significant "uptake" involving the left hip and left elbow and the Tenant was subsequently brought to a hospital emergency room for evaluation. Radiographs revealed fractures at both sites. Hospital records indicated Tenant #1 was admitted on 9-20-13 with admitting diagnoses of Pelvic Rami fracture, Elbow fracture and L-1 – L3 compression fractures.

Tenant #1 was discharged from the hospital on 9-30-13. Discharge instructions included a non weight bearing of left arm and keeping the arm elevated and keeping the cast dry, weight bearing as tolerated to lower extremities, assistance with ADLs, including bathing, dressing, transfer and toileting.

Functional, cognitive and health evaluations were completed on 9-30-13. Tenant #1's family had requested 24-hour private duty care in addition to staff assistance until Tenant #1's health improved. A service plan of 9-30-13 established interventions related to left arm care and the assistance of a private care giver for assistance with ADLs.

Staff #1, #2, and #3 were interviewed. Each stated tenants in the dementia unit have call pendants available to use; however, all three staff members indicated tenants in the dementia unit are checked frequently. Staff #1 and #2 stated tenants are observed constantly when in the common area, and every 10 minutes when not easily observed. All three staff members stated chair pad alarms were used as indicated by the nurse.

Staff #1, #2, #3 stated Tenant #1 had 24 hour a day, 7 day a week private caregiver who provides personal cares. Program staff provided general supervision and administered medications.

- Regulatory Insufficiency: None noted.