IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #: 45488-C

November 1, 2013

Ms. Jill Colling, Director
Bickford Cottage II Memory Care AL
4022 Indian Hills
Sioux City, IA 51108

RE: Final Complaint/Incident Investigation Report, Bickford Cottage II Memory Care AL, Sioux City, Iowa

Dear Ms. Colling:

Enclosed is the **Final Complaint/Incident Investigation Report** 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 found during this onsite investigation.**

If you have any questions in regard to 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:

Jill Colling, Director
Bickford II Memory Assisted Living
4022 Indian Hills
Sioux City, IA 51108

Complaint/Incident Intake #: 45488-C

Date of Complaint/Incident Investigation:

October 15, 2013

Monitor(s):

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.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	21
Total Population of Program at time of on-site	23
TOTAL census of Assisted Living Program	23

Program History – The program received regulatory insufficiency in the area of Criteria for Admission and Retention of Tenants during this certification period.

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged tenant apartments were dirty. It was alleged tenants were incontinent of urine and stool, were unattended long enough for moisture to soak through clothing, and staff members needed to be told to perform personal cares.

Monitoring Observation: During the course of the onsite visit, the monitor observed apartments occupied by Tenants #1, #3, #4, #5, #6, #7, #8 representing hallways A, B, C, and D. Apartments belonging to Tenants #1, #4, #5, #6, and #7 were observed to be generally clean and without malodors.

At approximately 11:00 a.m., the monitor entered Tenant #3's apartment with Tenant #3 and Staff #1. The purpose for entering the apartment was the scheduled toileting of Tenant #3. The apartment was generally clean. There were no malodors in the entryway or bathroom. As the monitor neared the bed, an odor of urine was present. The bed was stripped except for the mattress pad which appeared to have urine soiling. The odor and soiled mattress pad was brought to the attention of Staff #1. Staff #1 removed the soiled mattress pad and placed it in the laundry.

At approximately 1:30 p.m., the monitor asked the program nurse to walk down hallway A. The odor of urine was observed by the monitor and the program nurse at the end of that hallway, closest to the main entrance. The odor did not extend the length of the hallway. The program nurse entered Tenant #8's apartment after knocking. Tenant #8's apartment was in the area of the odor in hallway A. Generally, the carpet was in need of vacuuming.

An odor of urine was present in the apartment. The bathroom was generally free of odor and the garbage was empty. The program nurse sniff tested and reported no odors from the chair or the bed. The odor was present in the room in the area closest to the bed. There were no obvious stains on the carpet. There was no odor about Tenant #8. The program nurse stated she would instruct maintenance to clean the carpet.

The hallways and common areas of the program were observed every 1.5 to 2 hours. There were no malodors noted, with the exception of hallway A, while walking through the areas. The furniture was observed to be dry. Tenants were also observed during the walk-throughs. None of the tenants were observed to have wet or soiled clothing. None of the tenants was noted to have body odors.

Staff #4 was interviewed and stated all the tenants were toileted every two hours. Staff #4 stated she has found clothing or furniture wet when getting tenants up to toilet. Staff #4 stated tenants can be wet after toileting because some tenants do not urinate when placed on the toilet and there is no control as to when tenants urinate.

At approximately 8:45 a.m. Tenant #9 was observed being assisted to the restroom by Staff #1. The seat area of Tenant #9's pants was dry. Staff #1 assisted Tenant #9 to remove disposable undergarments. The undergarments and the skin of Tenant #9 had visible stool present. Staff #1 was observed to clean the stool from the skin before Tenant #9 sat on the toilet. Staff #1 observed Tenant #9 needed a clean shirt. Staff #1 removed the shirt and assisted Tenant #9 with a new shirt. After Tenant #9 used the toilet, Staff #1 was observed using moist towelettes to provide perineal hygiene. Staff #1 had placed the soiled undergarment in the garbage and proceeded to secure the garbage and take it outside.

At approximately 9:00 a.m. Tenant #2 was observed being assisted to the restroom by Staff #2. Staff #2 was observed to check the absorbent undergarments for moisture. The undergarments were reported to be dry. The seat area of Tenant #9's pants was dry. After Tenant #2 finished on the toilet, Staff #2 was observed using a moist towelette to provide perineal hygiene. Staff #2 was observed securing the garbage and removing it after toileting was completed.

At approximately 9:10 a.m. Tenant #3 was observed being assisted to the restroom by Staff #2. Staff #2 observed the absorbent undergarments were wet. The seat area of Tenant #3's pants was dry. The undergarments were removed and placed in the garbage. Tenant #3 proceeded to have a bowel movement in the toilet. Staff #2 was observed to use moist towelettes to provide perineal hygiene after toileting. The garbage was removed.

At approximately 11:00 a.m. Tenant #3 was observed being assisted to the restroom by Staff #1. Tenant #3's clothing was observed to be dry. Staff #1 observed the absorbent undergarments were dry. Tenant #3 was seated on the toilet but did not urinate. Staff #1 cleansed Tenant #3 with moist towelettes after determining Tenant #3 was not going to use the toilet.

At approximately 4:35 p.m. Tenant #6 was observed being assisted to the restroom by Staff #3. Tenant #6's clothing was observed to be dry. Staff #3 reported the undergarments were damp and removed them. After toileting, Staff #3 used moist towelettes to provide perineal hygiene after toileting. The garbage was secured and removed.

Eight apartments were observed with two noted having odors of urine present. Three staff were observed providing hygiene after toileting on five occasions with four different tenants. None of the tenants had soiling of exterior clothing prior to toileting. Staff provided perineal hygiene after toileting on all five occasions.

According to Iowa Administrative Code 481-67.10(3), the department shall use the preponderance-of-the-evidence standard for determining whether a regulatory insufficiency exists.

There was not a preponderance of evidence to support the allegations.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation: It was alleged there were not enough staff members present to prevent falls.

- Monitoring Observation: The program provided documentation of three staff members available for the day and evening shifts, and two staff members available for the night shift. There were three staff members observed working on the day of the onsite visit. The staffing pattern was confirmed in interviews with Staff #1 and #4. Staff #1 stated housework does not always get done on the night shift, but did not identify any tenants as not receiving cares needed. Staff #4 did not identify any issues with staffing.

  Tenant #1, a 74 year-old, was admitted on 8-17-13 and had diagnoses of: Dementia and Diabetes Type II. Tenant #1 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline.

  The initial evaluations and service plan dated 8-16-13 indicated Tenant #1 was independent with ambulation and transfers. Progress notes dated 9-12-13 documented Tenant #1 continued to have a steady gait and was independent with ambulation and transfer. The progress notes indicated Tenant #1 had become agitated and had been prescribed Ativan. Two falls occurred after the Ativan had been prescribed. No injuries were noted. The Ativan was discontinued. The service plan was updated on 9-12-13 to indicate Tenant #1 was at risk for falls. Staff was directed to assist Tenant #1 when an observation of unsteadiness was made.

Incident reports dated 9-29-13 indicated Tenant #1 was running down the hall and lost balance, and 10-6-13 indicated Tenant #1 attempted to sit in a chair and missed the seat. A staff member observed the incident but was unable to reach Tenant #1 before he/she landed on the floor. There was no documentation of any fall after 10-6-13.

During the monitoring visit of 10-15-13, a staff member was observed to assist Tenant #1 with ambulation when observed to be unsteady. Tenant #1 was also observed during the onsite visit to ambulate independently with a steady gait.

Tenant #6, an 87 year-old was admitted on 7-2-12 and had diagnoses of: Dementia, Hypertension, Anxiety, and Elevated Blood Sugars. Tenant #6 was staged at six on the GDS which indicated severe cognitive decline. Evaluations and a service plan update were completed on 8-9-13 following discharge from hospice. The service plan indicated Tenant #6 had a history of restlessness and anxiety, and was a fall risk. An "as needed" medication was ordered. Tenant #6 was noted to try to get up on his/her own. Staff was directed to use bed and chair alarms at all times. Staff members were to assist with transfers, and assist with standing or walking. Tenant #6 was propelled in a wheelchair by staff members.

On 8-26-13, Tenant #6 was heard calling for help. Tenant #6 was found on the floor near the wheelchair with a skin tear. Tenant #6 was returned to the wheelchair and a dressing applied to the skin tear.

On 9-26-13, the chair alarm sounded and Tenant #6 was found sitting on the floor by the wheelchair. No injuries were noted. The physician was notified.

On 10-15-13 at approximately 4:35 p.m. Staff #3 was observed toileting Tenant #6. A working chair alarm was observed in the wheelchair.

The service plan identified Tenant #6 was a fall risk. Interventions were in place for falls. Staff responded to requests for assistance on two occasions, one month apart, and found Tenant #6 on the floor. Tenant #6 did not sustain a major injury.

Tenant #10, an 80 year-old, was admitted on 12-5-12 and had diagnoses of: Chronic Lymphatic Leukemia, Dementia, and Chronic Pain. Tenant #10 was staged at five on the GDS which indicated moderately severe cognitive decline. Evaluations of function, cognition, and health were completed on 8-7-13 and the service plan was updated. The service plan indicated Tenant #10 was independent with ambulation and transfers. Tenant #10 used a walker when ambulating. The service plan indicated Tenant #10 was at risk for falls and staff members were to report when Tenant #10 was unsteady.

An incident report dated 8-8-13 indicated Tenant #10 was in the dining room. A staff member heard a noise and turned to find Tenant #10 on the floor. Tenant #10 hit the head but denied pain. The program nurse completed a nurse review and no significant changes were observed. The physician was notified.

An incident report dated 9-4-13 indicated Tenant #10 was in the hallway. A staff member was also in the hallway, heard a noise, and looked up to find Tenant #10 falling forward, grabbing a handrail, and then falling to the floor. Tenant #10 bumped the head. A nurse review was completed.

An incident report dated 10-3-13 indicated Tenant #10 was found on the floor in the hall without the walker. Tenant #10 complained of lip pain and his lip was a little swollen. Tenant #10 may have bit the tongue. A nurse review was completed. Tenant #10 was independent with ambulation and transfer and used a walker. Tenant #10 experienced three falls, each approximately one month apart. Tenant #10 did not sustain a major injury.

Tenant #11, a 99 year-old, was admitted on 1-29-08 and had diagnoses of: Alzheimer's, Degenerative Joint Disease, Osteoporosis, and Coronary Artery Disease. Tenant #11 was staged at six on the GDS which indicated severe cognitive decline. An incident report dated 8-23-13 documented Tenant #11 was found on the floor at 1:45 a.m. No injuries were noted. A nurse review was completed. In an interview with the program nurse, she stated Tenant #11 had been sleeping in a recliner and had been moved to the bed. After the fall, the program instituted a mattress on the floor next to the bed.

An incident report dated 9-4-13 and timed 7:30 a.m. documented Tenant #11 was found by a staff member on the mattress by the bed. A small cut was noted by the right eye. A nurse review was completed and identified an abrasion near the right eye. The nurse review documented safety measures were in place. Evaluations were completed on 9-5-13 and the service plan was updated. The service plan included the mattress on the floor by the bed for safety. There were no documented falls after 9-5-13.

Tenant #13, an 87 year-old, was admitted on 10-26-11 and had diagnoses of: Dementia, Anxiety, Hypertension, and History of Walking Constantly. On 4-22-13, Tenant #13 was staged at six on the GDS which indicated severe cognitive decline.

In a fax to the physician dated 4-3-13, Tenant #13 was found on the floor of the apartment with an abrasion to the spine. The fax also documented the program spoke to the family about the need for a private caregiver to provide one-to-one assistance daily.

The evaluations of 4-22-13 identified Tenant #13 as at risk for falls. The service plan of the same date indicated a private caregiver had been hired from 9:00 a.m. to 9:00 p.m. to assist Tenant #13 to walk with a walker. Tenant #13, who had a history of walking constantly, required assistance with ambulation. The service plan identified the use of chair and bed alarms during the hours the private caregiver was not available, and changes to medications. The progress notes also documented the family was discussing options for Tenant #13.

A fax to the physician dated 5-6-13 indicated the alarm sounded and Tenant #13 was found on the floor with an abrasion to the face. Progress notes dated 5-14-13 indicated the alarm sounded and Tenant #13 was found on the floor of the apartment. No injuries were documented.

The progress notes of 5-20-13 indicated per the family's request information was provided to another facility. The family gave notice on 6-6-13 of the intent to leave the program and Tenant #13 was discharged from the program on 6-14-13.

The service plan identified Tenant #13 was a fall risk. Interventions were in place for falls. Tenant #13 sustained two falls after 4-22-13. Neither of the falls resulted in major injury. Tenant #13 was discharged on 6-14-13.

Iowa Administrative Code 481-69.29(4) indicates tenants in a dementia-specific program are to be monitored according to the service plan and staff members are to be in the proximate area.

The clinical records were reviewed for Tenants #1, #6, #10, #11 and #13. All of the tenants has sustained falls, but none with major injury. The program followed the service plans in providing services related to ambulation and falls. Three staff members were observed at the program on the day of the onsite visit, which followed the program's staffing plan. Staff members were in the proximate area of the tenants.

- Regulatory Insufficiency: None noted.

C. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged tenants required more care than was provided by the program.

- Monitoring Observation: Interviews were conducted with Staff #1, #2, and #4. No tenants were identified through interview that required routine two-person assistance, displayed unmanageable incontinence or who did not assist in some way with cares. Staff #1, #2, and #4 identified Tenant #1 as having a history of striking staff. Staff #1 stated Tenant #1 did not like to be touched, and was hard to redirect. Staff #2 stated has not attempted to grab at staff in the last two weeks. Staff #4 stated none of the tenants was hard to redirect.

  Staff #1 identified Tenant #6 as standing up constantly and was a fall risk. Staff #2 identified Tenant #11 as a one-person transfer, but difficult.

  Tenant #1 was identified by Tenant #1 was admitted from home on 8-17-13. Progress notes at 30 days, dated 9-12-13 documented Tenant #1 was agitated and pacing with an episode on 9-5-13 of punching a staff member who was helping Tenant #1 shower. Progress notes also documented Tenant #1 was exit-seeking. Medications were changed and the service plan of 9-12-13 was updated to include exit-seeking behaviors and to instruct staff to not reach out and grab Tenant #1.

  Progress notes dated 9-16 thru 10-7-13 documented Tenant #1 was seen by a neurologist and medications were adjusted. No behaviors were observed.

On 10-8-13 at 1:30 a.m., Tenant #1 who was wearing a wander-guard device was noted to be exit-seeking. The incident report documented a staff member was blocking the door and was struck by Tenant #1. The staff member moved and Tenant #1 left the building observed by staff and was returned.

On 10-9-13 at 1:30 a.m. Tenant #1 was exit-seeking after being up all night. A staff member attempted to redirect Tenant #1, and was struck in the arm by Tenant #1. Progress notes documented the physician was contacted later in the day and medications were adjusted.

On 10-9-13 evaluations were completed and the service plan was updated to include specific interventions to include not blocking the door and not rushing at Tenant #1. The incident report documented staff members were education on the interventions for behaviors.

There were no incident reports after 10-9-13 documenting any behaviors. Staff had been educated on the interventions put in place and medications were adjusted. The progress notes 10-9 through 10-15-13, the date of the monitoring visit, documented no behaviors. Tenant #1 was observed throughout the day of the monitoring visit and was observed to be calm and no behaviors were observed.

Tenant #12, a 79 year-old, was admitted on 5-10-12 and had diagnoses of: Alzheimer's, Osteoporosis, Arthritis, and Anxiety. Tenant #12 was staged at six on the GDS which indicated severe cognitive decline.

The progress notes dated 5-20-13 indicated Tenant #12 walked independently around the program, went to the doors, but was easily directed. On 5-21-13, Tenant #12 exited the building, the alarms sounded and staff responded. Private duty staff was hired to sit with Tenant #12 daily from 5:00 p.m. to 10:00 p.m. Evaluations were completed and the service plan was updated and included the elopement risk and the private duty staff due to the elopement risk. The Department of Inspections and Appeals was notified of the elopement according to the progress notes. The notes documented conversations with the family regarding Tenant #12.

On 6-10-13 the progress notes documented the program applied for a waiver for Tenant #12 as Tenant #12 eloped and required the private duty staff because of the elopement risk. The program received notification on 6-24-13 that the waiver request had been denied. Tenant #12 was discharged from the program on 7-22-13.

The program identified Tenant #12 exceeded criteria for retention due to elopement. The program applied for a waiver to retain Tenant #12 despite exceeding criteria. The waiver was denied. Tenant #12 was discharged.

Tenant #13 had a history of walking constantly and was identified to be at risk for falls. Tenant #13 had a private caregiver for 12 hours a day and chair and bed alarms were used when the caregiver was not present. Tenant #13 had two falls after the caregivers were implemented. Neither fall resulted in major injury. Tenant #13 was discharged from the program.

Three tenant files were reviewed. Tenant #1 received medicinal and therapeutic interventions following the behavior of striking out and exit-seeking. At the time of the monitoring visit, the interventions were successful.

The program identified Tenant #12 as exceeding criteria for retention and asked the department for a waiver. When the waiver was denied, Tenant #12 was discharged.

Tenant #13 was at risk for falls and walked constantly. A private caregiver was retained to maintain safety. Tenant #13 was voluntarily discharged from the program.

- Regulatory Insufficiency: None noted.

D. Structural Requirements

Complaint/Incident Allegation: It was alleged the program had a very strong odor.

- Monitoring Observation: Iowa Administrative Code 481-69.35(1)(b) requires buildings and grounds to be well-maintained, clean, safe and sanitary.

The monitor entered the program shortly before 8:00 a.m. on the day of the monitoring visit. Upon entering the program, no malodors were noted. The building was toured including hallways A, B, C, and D. There were no malodors present in hallways B, C, and D. There was an odor of urine present near two rooms in the A hallway, the rooms closest to the main entrance.

The Great Room and Sitting Room near the main entrance were observed. The Great Room had two cloth couches, three vinyl-covered chairs, and five cloth chairs. One cloth chair was observed to have a dry stain. All the furniture was sniff tested for an odor of urine. No odors were noted. The furniture was dry.

The Sitting Room was observed to have a cloth couch with no odors or stains. There were two vinyl chairs and two cloth chairs. One of the cloth chairs was occupied but later checked. The furniture in the Sitting Area was clean, dry, and odor free.

The Living Area located in the B hallway had a vinyl-covered couch and three cloth chairs. No stains or odors were present on the furniture or in the seating area. The furniture was dry.

The Living Area located in the C hallway had a cloth three-cushion couch and three cloth chairs. The chairs were without odor and stain. There were no odors noted in the seating area when standing. The sniff test was completed at a distance of approximately two inches from the surface of the couch. An odor of urine was detected. The couch cushions were dry.

The odor in the couch cushions was brought the attention of the Program Nurse. She reported contacting maintenance immediately to clean the cushions. The cushions were observed to be off the couch approximately one hour later.

The Library where the television was located was observed to have no cloth furniture. The area was generally clean with no malodors. The furniture was dry.

The hallways and common areas of the program were observed every 1.5 to 2 hours. There were no malodors noted, with the exception of hallway A, while walking through the areas. The furniture was observed to be dry.

During the course of the onsite visit, the monitor observed apartments occupied by Tenants #1, #3, #4, #5, #6, #7, #8 and #9 representing hallways A, B, C, and D. Apartments belonging to Tenants #1, #4, #5, #6, #7, and #9 were observed to be generally clean and without malodors.

At approximately 11:00 a.m., the monitor entered Tenant #3's apartment with Tenant #3 and Staff #1. The purpose for entering the apartment was the scheduled toileting of Tenant #3. The apartment was generally clean. There were no malodors in the entryway or bathroom. As the monitor neared the bed, an odor of urine was present. The bed was stripped except for the mattress pad which appeared to have urine soiling. The odor and soiled mattress pad was brought to the attention of Staff #1. Staff #1 removed the soiled mattress pad and placed it in the laundry.

At approximately 1:30 p.m., the monitor asked the program nurse to walk hallway A. The odor of urine was observed by the monitor and the program nurse at the end of the hallway closest to the main entrance. The odor did not extend the length of the hallway. The program nurse entered Tenant #8's apartment after knocking. Tenant #8's apartment was in the area of the odor in hallway A. Generally, the carpet was in need of vacuuming. An odor of urine was present in the apartment. The bathroom was generally free of odor and the garbage was empty. The program nurse used the sniff test and reported no odors from the chair or the bed. The odor was present in the room in the area closest to the bed. There were no obvious stains on the carpet. There was no odor about Tenant #8. The program nurse stated she would instruct maintenance to clean the carpet.

According to Iowa Administrative Code 481-67.10(3), the department shall use the preponderance-of-the-evidence standard for determining whether a regulatory insufficiency exists.

Four hallways were observed. One, hallway A, was noted to have a malodor. The Great Room, Sitting Room, Library, and two Living Areas were observed. All had multiple pieces of furniture. One couch in one Living Area was observed to have a urine odor with a sniff test completed at a distance of approximately two inches. Eight apartments were observed with two having odors of urine.

While a deviation from the requirements of the rules was found, it did not meet the standard set forth in rule 67.10(3) for determining that a regulatory insufficiency exists.

- Regulatory Insufficiency: None noted.