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 #:
45540-I

November 15, 2013

Ms. Samantha M. Hadden, Director
Bickford Cottage Iowa City
3500 Lower West Branch Road
Iowa City, IA 52245

RE: Final Complaint/Incident Investigation Report, Bickford Cottage Iowa City, Iowa City, Iowa

Dear Ms. Hadden:

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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC.

If you have any questions in regard to 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 #:** 45540-I

Samantha M. Hadden, Director
Bickford Cottage Iowa City
3500 Lower West Branch Road
Iowa City, IA 52245

Date of Complaint/Incident Investigation:

October 17 and 21, 2013

Monitor(s):

Stephanie Cummins, MA

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:	35
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	39
TOTAL census of Assisted Living Program	39

Program History – The Program has not received any regulatory insufficiencies during this certification period.

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

A. Policies and Procedures

Complaint/Incident Allegation: The Program reported a tenant followed a visitor out of the Program. Staff saw the tenant in the parking lot and brought the tenant back in the Program without incident.

- Monitoring Observation: Tenant #1, an 80 year old, was admitted on 7-24-11 and diagnoses included: Poor Short Term Memory, Mild Dementia, Memory Disturbance, Polymyalgia Rheumatica, History of Giant Cell Arteritis, Hypertension, Well Controlled Diabetes Mellitus Type 2, Melanoma, Kidney Stones and Osteopenia. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline.

  According to an incident report (the incident report indicated to see report on attached sheet), the date was 8-19-13 and time was 3:08 p.m. It was witnessed by no one and the person involved was Tenant #1. The front door area was indicated as the location.

  A typed document titled Incident Report indicated at approximately 3:06 p.m. Staff #2 looked out the laundry room window and noticed Tenant #1 walking into the parking lot with another person. Staff #2 felt it was odd as Tenant #1 never went out so she immediately left the laundry room and walked to the living room to check the tenant sign-out book. It was noted Tenant #1 had not been signed out and Staff #2 saw Staff #3 coming into the living room and requested Staff #3's assistance. They went outside to find Tenant #1 standing by another tenant's vehicle attempting to find keys to unlock it and the person who stocked the pop machine (Visitor #1) was getting into Visitor #1's vehicle. Staff #3 stopped Visitor #1 and spoke with Visitor #1 about allowing the tenants to leave the building behind Visitor #1 without checking with staff to see it if was permissible. Tenant #1 came back into the

building without incident. The temperature at the time was 74 degrees. Tenant #1 was wearing socks and tennis shoes, light weight pants and a blouse with three quarter length sleeves. Upon re-entering the building it was noted Tenant #1's wandering monitoring device alarmed. The Registered Nurse (RN) Coordinator assessed Tenant #1 once Tenant #1 was back in the building. No injuries were noted and Tenant #1 denied complaints. Tenant #1 appeared at Tenant #1's usual baseline mentation and appeared well hydrated. Tenant #1's wandering monitoring device was tested at the door again at 3:18 p.m. and alarmed.

According to Progress Notes dated 8-19-13, Tenant #1 was standing by the door as Visitor #1 was going out and followed Visitor #1 out of the building. Staff noticed Tenant #1 through a window and went outside to assist Tenant #1 back in. Tenant #1 came back in agreeably and the wandering monitoring device alarmed when Tenant #1 re-entered the building and again when tested a second time. Tenant #1 re-entered the building at 3:08 p.m. and appeared to have no ill effects from the incident. The family and physician were notified.

According to the State Climatologist, in Iowa City on 8-19-13 at 3:00 p.m. the temperature was 83 degrees, winds were from the southwest at 8 to 17 miles per hour (mph), there were partly cloudy skies, the heat index was 84 degrees and there was no precipitation.

The Divisional Director of Operations had a typed statement. According to the statement, on 8-19-13 Staff #1 unlocked the front door for a visitor. At that time Tenant #1 was standing in the front door area and Tenant #1's wandering monitoring device alarmed as Tenant #1 was within the alarming parameter inside the building. Staff #1 reset the wandering monitoring device alarm. Visitor #1 was coming in and out of the building loading soda. At 3:06 p.m. Tenant #1 walked out of the building with Visitor #1. Staff in the laundry room saw Tenant #1 outside and escorted Tenant #1 back in the building without incident. Door alarm records indicated Visitor #1 last opened the door at 3:06 p.m. and staff reset the wandering monitoring alarm at 3:08 p.m. when it went off from bringing Tenant #1 back in the building. Tenant #1 did not have any adverse effects from the incident. The weather was approximately 74 degrees and Tenant #1 was dressed in light pants, a blouse with three quarter length sleeves and socks and tennis shoes. Numerous checks were made testing the door alarms following the incident and all equipment functioned properly.

Staff #1 said Visitor #1 had the code to the door. When Visitor #1 had come back out the wandering monitoring alarm was reset. Tenant #1 was in the building, the door was alarmed and the wandering monitoring system was on. It was no more than a few minutes from when Tenant #1 was last seen to when Tenant #1 was outside. Tenant #1 ambulated independently and was dressed appropriately. Tenant #1 did not have any injuries. Staff followed the policies and procedures and Tenant #1 was brought back into the building safely.

Staff #2 was interviewed and had a written statement. At approximately 3:15 p.m. she went to the laundry room to start some laundry. She looked out the window and noticed a person she had never seen (Visitor #1) walking and Tenant #1 walking to a van parked in the parking lot. She ran and got Staff #3 and they went outside to get Tenant #1 and brought Tenant #1 back inside. Staff #3 told Visitor #1 to never let a

tenant out of the building without asking a nurse first. Tenant #1 ambulated independently and did not sustain any injuries. Tenant #1 did not have a history of elopements and she was not aware of any subsequent elopements. Staff followed the policies and procedures and the incident was handled appropriately.

Staff #3 said Staff #2 saw Tenant #1 outside with Visitor #1. Tenant #1 was trying to get into a van (which belonged to other tenants) in the parking lot. Visitor #1 was in Visitor #1's vehicle with the door open. Staff #3 directed Tenant #1 back in the building. Staff #3 told Visitor #1 to check with staff before letting a tenant out of the building. Tenant #1 ambulated independently and did not have any injuries. Tenant #1 was dressed appropriately. She said Tenant #1 was outside less than one minute. Staff followed the policies and procedures and the incident was handled appropriately.

The RN Coordinator said she was at the front desk and Visitor #1 had made two or three trips in and out of the building. Tenant #1 was standing by the door. She watched Tenant #1 walk out the front door (kind of with Visitor #1). Staff #2 came out and asked if it was known Tenant #1 was outside. Staff went outside and brought Tenant #1 back in the building. Tenant #1 was outside maybe two to three minutes. Tenant #1 had no injuries and was dressed appropriately. Tenant #1 ambulated independently and was located in the parking lot. Tenant #1 had did not have a history of elopements. As interventions the signs on the door were revised and were larger and clearer. There was an activity basket and Seroquel twice daily was added. Activity staff took Tenant #1 for walks during the difficult hours, staff gave Tenant #1 a snack and Tenant #1 sat with others in the dining room. She said Tenant #1 was safe. Staff followed policies and procedures and the incident was handled appropriately.

Review of incident reports and Tenant #1's file indicated there was another incident with Tenant #1. According to an incident report, the location was the dining room/front door, the date was 9-29-13 and the time was 1:00 p.m. The person involved was Tenant #1. It was witnessed by staff. The description of the incident indicated staff was standing by the edge of the dining room and watched another tenant's family member hold the door open for Tenant #1. Tenant #1 stepped outside and into the parking lot. Staff watched Tenant #1 the "whole time." Staff went to the front door and directed Tenant #1 back in the building with no problem.

According to the State Climatologist, in Iowa City on 9-29-13 at 1:00 p.m. the temperature was 67 degrees, winds were the south at six mph, there were clear skies and no precipitation.

According to Progress Notes dated 9-29-13, Tenant #1 was standing near the door when an incoming visitor held the door open and Tenant #1 walked out. The wandering monitoring device alarmed. Staff visualized Tenant #1 walking out and accompanied Tenant #1, then redirected Tenant #1 back into the building without incident. Tenant #1 was outside for approximately one minute on the Program's porch.

According to the Exit Door Inspections policy, all exit doors should be inspected and maintained to ensure appropriate functioning at all times. Maintenance inspected all

exit doors weekly to ensure they were functioning appropriately. The Exit Doors Inspection Checklist documents from 8-15-13 to 10-10-13 were reviewed and the exit doors were inspected weekly.

The wandering monitoring system was checked with an extra device at the time of the investigation and functioned appropriately. Signs were posted to remind people to look behind them and make sure no one was following and some of the tenants looked like visitors. The signs indicated it was important for their safety that it was only the person and their party exiting the building.

An incident report was completed for the incident on 8-19-13 and the incident was reported to the Department. An incident report was completed related to the incident on 9-29-13.

According to the Program's Incident and Accident Report policy, tenant, staff or visitor incidents or accidents were to be reported and documented immediately after they occurred. Incidents or accidents included but were not limited to: medication errors, staff or visitor injuries and tenant falls or injuries. Vital signs should be taken and documented on each incident report.

Incident reports were completed for the incidents on 8-19-13 and 9-29-13; however, vital signs were not recorded on the incident report as indicated per program policy. While a deviation from 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.

B. Program Reporting to the Department

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #2, a 77 year old, was admitted on 9-30-11 and diagnoses included: Arthritis, Seizure Disorder, Dementia, Status/Post Cerebral Vascular Accident, Benign Prostate Hypertrophy, History of Alcohol Abuse and Aphasia. Tenant #2 was staged at three on the GDS, which indicated mild cognitive decline.

  According to an incident report dated 8-20-13 at 8:10 a.m. staff heard a smoke alarm sounding in Tenant #2's apartment. Staff investigated and found smoke throughout the apartment. Upon entering the bathroom staff noted smoke coming from a plastic garbage can. At that time staff initiated the emergency procedure to evacuate the building and notify the fire department. The physician and family were notified.

  According to the Fire Report, they responded to the Program for a reported fire in an apartment. Upon arrival, evacuation was complete and the fire alarm was sounding. It was reported everyone was out of the building and the fire was located in Tenant #2's apartment. They entered the room to find a self-extinguished fire in a trash can.

There was very light smoke in the room and in the hallway attached to the apartment. There was no active fire and no extension. It was determined an ashtray had been dumped into a plastic trash can that contained toilet paper. Hot ashes had ignited the toilet paper and other items in the trash can. Ventilation was started and all smoke was removed from the apartment and hallway. Program staff reset the fire alarm and tenants were let back in the building. The fire was determined to be accidental in nature and confined to the trash can. There were no estimated dollar losses or values noted.

According to Progress Notes dated 8-20-13, at approximately 8:00 a.m. Tenant #2 dumped ashes from an ashtray into a plastic bathroom trash can. The contents then began smoking and set off the smoke detector and alerted staff. Staff activated the emergency response plan and put water in the trash can. The fire department arrived and confirmed no fire was present. Paramedics evaluated Tenant #2 and found no injuries. Tenant #2 did not appear to comprehend the seriousness of the situation and potential for serious injury. Tenant #2 was informed Tenant #2 would no longer be able to smoke in the apartment. Cigarettes and lighters were removed from the apartment with Tenant #2's permission. Tenant #2's physician was contacted to initiate smoking cessation therapy. Tenant #2's family was contacted and was in agreement with the no smoking plan. According to Progress Notes dated 8-20-13, the RN Coordinator met with Tenant #2 to initiate electronic cigarette use.

Evaluations and the service plan were completed after the incident. The service plan reflected the incident and the use of electronic cigarettes.

Staff #3 said she was going down a hall with another tenant and heard beeping. The smoke detector in Tenant #2's apartment was going off and she could smell smoke. There was a trash can that had smoke but no flames and there was nothing around the trash can. Tenant #2 was in the bedroom in the wheelchair and was told to get out of the apartment. Staff #3 pulled the main fire alarm system. Another staff called 911 and staff evacuated the building. Emergency staff arrived. There was no structural damage and the trash can did not melt. Tenant #2 had dumped an ashtray in the trash can. There had been no prior issues similar to the incident with Tenant #2. All cigarettes and lighters were removed from the apartment. Tenant #2 had electronic cigarettes.

The RN Coordinator said there were no injuries and no structural damage. The trash can did not melt. There had been no prior or subsequent issues with Tenant #2. Since the incident Tenant #2 used electronic cigarettes.

According to the Divisional Director of Operations, there was no actual fire and no flames. The main alarm did not go off and it was the alarm in Tenant #2's apartment. Staff pulled the alarm for evacuation. There was no structural damage and no prior issues with Tenant #2.

Review of incident reports, a tenant file and staff interviews indicated the Program did not report the incident on 8-20-13 to the Department.

- Regulatory Insufficiency: The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available:

When a fire occurs in a program and the fire requires the notification of emergency services, requires full or partial evacuation of the program, or causes physical injury to a tenant. (IAC r. 481-67.4(6))

C. Service Plans

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #1's file was reviewed. According to an Assisted Living Visit Note, Tenant #1's weight was down 10 pounds from August and 27 pounds from July. The Impression and Plan indicated a 10 pound weight loss since August. It also indicated a nutritional supplement three times daily, continue to monitor oral intake and monthly weight. Encourage Tenant #1 to eat, even if Tenant #1 did it while pacing. Finger foods were desirable. A nutritional supplement three times per day was ordered 9-30-13. The nutritional supplement was reflected on the October 2013 Medication Administration Record. The weight loss and nutritional supplement were not reflected on the service plan.

Tenant #1's service plan dated 10-2-13 did not reflect weight loss and the nutritional supplement. Tenant #1's service plan did not reflect the identified needs of Tenant #1.

Tenant #3, a 78 year old, was admitted on 5-2-11 and diagnoses included: Dementia, Moderate Alzheimer's and Depression. Tenant #3 was staged at a five on the GDS, which indicated moderately severe decline. Tenant #3 had an order for Epsom Salt Soaks every day. The order was dated 9-30-13. The service plan did not reflect the Epsom Salt Soaks every day. An order was received dated 10-22-13 to discontinue the Epsom Salt Soaks.

According to Progress Notes dated 9-20-13, Tenant #3 fell in room as Tenant #3 tipped his/her head back to take pills. Tenant #3 appeared to pass out prior to falling and had some questionable seizure like activity for 10-15 seconds following the fall. Tenant #3 had then "woke up" and had no memory of the incident. The incident was similar to one that occurred in late May and Tenant #3 was evaluated in the emergency room and no cause was determined. Progress Notes dated 5-28-13 indicated Tenant #3 fell in front of the medication room and the reason for the fall was unknown. Tenant #3 was taking medications at the time and fell backwards into the chair striking Tenant #3's head. It resulted in a laceration approximately three centimeters in length. An ambulance was called. Tenant #3 returned to the Program on 5-28-13 and had staples placed in laceration. The incidents were not reflected on the service plan.

The service plan did not reflect the identified needs of Tenant #3.

Review of tenant files indicated service plans did not reflect the identified of the tenants.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

D. Nurse Review

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #3's file was reviewed. Tenant #3 had an order for Epsom Salt Soaks every day. The order was dated 9-30-13. An order was received dated 10-22-13 to discontinue the Epsom Salt Soaks. The Treatment Administration Record (TAR) reflected the order for Epsom Salt Soaks, soak nightly to help with the removal of dried skin. The TAR for October 2013 did not reflect the completion of the treatment. The treatment was not completed consisted with the physician's order.

  Tenant #4, an 84 year old, was admitted on 8-5-07 and diagnoses included: Cerebral Palsy, Gastro Esophageal Reflux Disease and Urinary Tract Infection (recurrent). According to the service plan Tenant #4 had a chronically open pressure area on the right posterior thigh. Tenant #4 had a physician order for Exuderm RCD 4 x4, apply to right ischium, change and cleanse every 48 hours at bedtime. The schedule was daily at 8:00 a.m. and the order date was 7-29-11. There was another order for Exuderm RCD 4 x 4 apply to right ischium, change and cleanse every 48 hours as needed. The schedule was as needed and the order date was 7-29-11. There was another order for Exuderm RCD 4 x 4 apply to right ischium, change and cleanse every 48 hours at bedtime as needed. The schedule was as needed and the order date was 6-25-12. The October 2013 TAR indicated Exuderm RCD 4 x4, apply to right ischium, change and cleanse every 48 hours at bedtime (8:00 a.m.) was documented as completed 10-1-13 through 10-21-13 daily with an exception noted on 10-5-13. The TAR reflected Exuderm RCD 4 x 4 apply to right ischium, change and cleanse every 48 hours as needed did not reflect the treatment was completed. The TAR reflected Exuderm RCD 4 x 4 apply to right ischium, change and cleanse every 48 hours at bedtime as needed did not reflect the treatment was completed.

  There were three orders for Exuderm RCD 4 x 4 listed on Tenant #4's Physician Orders. One of the orders indicated Exuderm RCD 4 x4 apply to right ischium, change and cleanse every 48 hours at bedtime, daily at 8:00 a.m. The order indicated every 48 hours at bedtime; however, was scheduled daily at 8:00 a.m. The orders for Tenant #4's Exuderm were not clear and needed clarification as to the time and frequency the treatment was to be completed.

  Review of tenant files indicated treatments were not completed per order and treatment orders needed clarification to ensure the orders were current.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program. (IAC r. 481-69.27(2))