IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
45276-C
45289-I

December 10, 2013

Ms. Cindy Egdorf, RN Director
Bickford Cottage of Fort Dodge
1536 20th Avenue North
Fort Dodge, IA 50501

RE: Final Complaint/Incident Investigation Report, Bickford Cottage of Fort Dodge, Fort Dodge, Iowa

Dear Ms. Egdorf:

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 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Cindy Egdorf, RN Director
Bickford Cottage of Fort Dodge
1536 20th Ave. N
Fort Dodge, Iowa 50501

Complaint/Incident Intake #:

45276-C
45289-I

Date of Complaint/Incident Investigation:

October 9 and 10, 2013

Monitor(s):

Maribeth Freland RN
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 Definition	
Number of tenants without cognitive disorder:	30
Number of tenants with cognitive disorder:	8
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 Tenant Rights and Criteria for Admission and Retention 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: 45276-C: It was alleged a tenant was injured by another tenant during an altercation. 45289-I: The program reported two tenants got into a physical altercation with one of the tenants getting hit in the nose, resulting in two black eyes.

- Monitoring Observation: The monitors reviewed the program's incident reports from the previous three month period, identifying physical altercations occurring that involved Tenants #1, #2, #3, #4 and #5. The monitors reviewed the clinical records of the above identified five tenants.

  Tenant #1, an 86 year old, was admitted to the program on 7-18-13. Tenant #1 had diagnoses of Atrial Fibrillation, Congestive Heart Failure, Hypertension (HTN), Peripheral Vascular Disease, Coronary Artery Disease and Chronic Kidney Disease. Tenant #1 answered all but three questions correctly on the Mini Mental Status Examination (MMSE) completed on 8-1-13, indicating normal cognitive function.

  Tenant #2, an 86 year old, was admitted to the program on 3-27-10. Tenant #2 had diagnoses of Chronic Kidney Disease, HTN and Cervical Spine Stenosis. Tenant #2 answered all but four questions correctly on the MMSE completed on 8-21-13, indicating normal cognitive function.

Tenant #3, an 84 year old, was admitted to the program on 7-18-13. Tenant #3 had diagnoses of Arterial Heart Disease, Pulmonary Fibrosis and Chronic Urinary Tract Infections. Tenant #3 answered all but two questions correctly on the MMSE completed on 8-14-13, indicating normal cognitive function.

According to an incident report, dated 8-18-13, Tenant #1, Tenant #2 and Tenant #3 were seated at the same table in the common dining room area prior to the noon meal. Tenant #2 stood and punched Tenant #1 in the nose. Staff members immediately separated Tenant #1 and Tenant #2. Tenant #1 was noted to have immediate bruising under both eyes and a mark where eyeglasses had rested. Tenant #1's eyeglasses did not break.

During interview, Tenant #1 reported he had called for staff members to assist Tenant #3 when Tenant #3's oxygen tubing became wrapped up in his/her wheelchair wheels. Tenant #2 reportedly told Tenant #1 to help Tenant #3 his/herself. Tenant #1 admitted to calling Tenant #2 a profane word, which caused Tenant #2 to, approach Tenant #1 from behind securing Tenant #1's hands. Then Tenant #2 hit Tenant #1 in the nose twice. Tenant #1 reported his/her eyeglasses caused a small cut at the corner of his/her right eye and both eyes were blackened. Tenant #1 reported staff members had immediately separated him/her and Tenant #2. Tenant #1 reported he/she refused medical attention and did not want law enforcement contacted. Tenant #1 was cognitively intact and made his/her own decisions at the time of the altercation. Tenant #1 reported he/she had known Tenant #2 since high-school and neither had ever gotten along. Tenant #1 reported program administration had addressed the situation appropriately and Tenant #2 had not approached either Tenant #1 or Tenant #3 since the altercation.

During interview, Tenant #2 reported Tenant #1 called him a name and Tenant #1 told said he/she "wanted to have it out" with Tenant #2. Tenant #2 admitted to punching Tenant #1 "a couple of times". Tenant #2 reported program administration had spoken with him/her and had been told he/she would be "kicked out" with any further physical altercations. Tenant #2 reported no longer speaking to Tenant #1 and reported a plan "to leave Tenant #1 alone".

During interview, Tenant #3, who resided in the same apartment as Tenant #1, verified Tenant #1's recollection of the events of the altercation between Tenant #1 and Tenant #2 to be accurate. Tenant #3 verified Tenant #2 had not approached either Tenant #1 or Tenant #3 since the 8-18-13 incident.

According to nurse notes, the program registered nurse (RN) attempted to assess Tenant #1's injuries. Tenant #1 refused to allow the assessment, repeatedly stating "you can go now".

According to nurse notes, the program RN spoke with Tenant #2, giving Tenant #2 notice that any further physical altercations would result in involuntary discharge from the program. Tenant #2 was moved to a different dining room table at the opposite end of the common dining room for all meals.

Both Tenant #1 and Tenant #2's service plans were updated on 9-5-13 to reflect the controversy between the two. Both service plans directed staff members to separate the two tenants should either approach the other and identified activities to use for redirection. Both service plans directed staff members to contact the program RN immediately if redirection was unsuccessful and directed staff members to contact law enforcement if a physical altercation should occur again. Tenant #1 and Tenant #2 had no prior altercations prior to the 8-18-13 incident. Tenant #1 was injured during the altercation but refused medical attention, law enforcement and program nurse assessment. The program moved Tenant #2 to a different table within the dining room. Both Tenant #1 and #2's service plans were updated to reflect the controversy between Tenant #1 and Tenant #2. The service plans directed staff members how to follow up should another issue arise. No further altercations had happened since the initial altercation on 8-18-13.

Tenant #4, a 94 year old, was admitted to the program on 9-16-10. Tenant #4 had diagnoses of Dementia and Arthritis. Tenant #4 scored a 3 on the Global Deterioration Scale (GDS) completed on 9-19-13, indicating mild cognitive decline.

According to the incident report, dated 6-16-13, Tenant #4 hit Tenant #6 on the right side of his/her face, causing Tenant #6 to fall onto the floor, resulting in no injuries. According to the incident report, dated 9-18-13, Tenant #4 grabbed Tenant #6's hand tightly and refused to let go. When staff members intervened, Tenant #4 released Tenant #6's hand and then slapped Tenant #6 across the cheek, resulting in no injuries.

The program updated Tenant #4's service plan with direction to verbally redirect Tenant #4 by speaking calmly to him/her should Tenant #4 become upset. If redirecting verbally was unsuccessful, staff members were instructed to remove Tenant #4 from the area. If Tenant #4 refused to leave the area, staff members were to administer physician ordered medications used as needed for agitation. On 9-19-13 the program initiated a managed risk agreement notifying Tenant #4 he/she was to distance his/herself from Tenant #6 due to two past episodes of aggression toward Tenant #6.

Tenant #4's clinical record lacked any other episodes of aggression from Tenant #4 between 6-16-13 and 9-18-13 and none since the 9-18-13 episode. The program addressed Tenant #4's physical aggression with Tenant #6 by immediately separating the two tenants and updated Tenant #4's service plan to address the behaviors.

Tenant #5, a 67 year old, was admitted by the program on 5-15-13. Tenant #5 had diagnoses of Mixed Alzheimer's Type and Vascular Type Dementia with Behavioral Components, Major Depression Disorder with Moderate Psychotic Features, Generalized Anxiety Disease, Hallucinations/Delusions, Diabetes and HTN. Tenant #5 scored a 5 on the GDS completed on 8-14-13, indicating moderately severe cognitive decline.

According to Tenant #5's service plans, dated 5-23-13, 6-14-13 and 8-14-13, Tenant #5 communicated with one word sentences, often answering questions with words "junk" or "puppies". Tenant #5 was tall and had a flat facial affect. Tenant #5 wandered around the program, at times entering others apartments or attempting to exit seek.

According to the incident report, dated 10-1-13, Tenant #5 pushed Tenant #2, causing both to fall to the floor, resulting in Tenant #5 fracturing his/her clavicle. Tenant #2 suffered no injuries. According to the incident report, dated 10-9-13, Tenant #5 pushed Tenant #4 while walking in the enclosed courtyard. Tenant #4 did not fall or receive any injuries. The program immediately sent Tenant #5 to the emergency room for psychological evaluation and Tenant #5 had not returned to the program during the on-site visit.

During the course of the investigation, the monitors interviewed multiple tenants currently residing at the program.

During interview, Tenant #2 reported being afraid of Tenant #5. Tenant #2 reported Tenant #2 jumped on his/her back on 10-1-13 and both ended up on the ground. Tenant #2 reported he punched Tenant #5 while they were wrestling around in an attempt to get Tenant #5 off of him/her. Tenant #2 reported a previous occasion when Tenant #5 shoved Tenant #2 up against the hallway wall for no apparent reason. Tenant #2 reported he would often go to his/her apartment, close and lock the door when seeing Tenant #5 wandering the hallways.

During interview, Tenant #7 reported being fearful of Tenant #5. Tenant #7 reported Tenant #5 would walk up behind him/her at lunch on occasion and had entered Tenant #7's apartment and lay down on the bed to sleep about two to four weeks prior to the on-site visit. Tenant #7 reported he/she now kept the apartment door closed and locked to keep Tenant #5 away. Tenant #7 reported preferring to leave the door ajar for fresh air but doing so would allow Tenant #5 to enter uninvited.

During interview, Tenant #8 reported being afraid of Tenant #5. Tenant #8 reported at first Tenant #5 had a staff member one-on-one at all times. Sometime after admission, the one-on-one caregiver was removed. At this time, Tenant #5 began entering Tenant #8's apartment. Tenant #5 was found by Tenant #8 two to three times entering Tenant #8's apartment without permission and messing around in the apartment kitchen. Tenant #8 reported that Tenant #5 would often come up behind Tenant #8's spouse in the hallways. Tenant #8's spouse used a wheelchair. Tenant #5 would begin pushing Tenant #8's spouse without his/her permission and take the wheelchair in whatever direction Tenant #5 felt like. Tenant #8 indicated this scared his/her spouse. Tenant #8 now reported he/she keeps the apartment door shut and locked to prevent Tenant #5 from entering uninvited. Tenant #8 reported telling the Director of the program. The Director reportedly told Tenant #8 there was no need to be fearful and reportedly did nothing to prevent Tenant #5 from intruding on Tenant #8.

During interview, Tenant #9 reported being afraid of Tenant #5. Tenant #9 reported at first Tenant #5 had a staff member one-on-one at all times. Sometime after admission, the one-on-one caregiver was removed. At this time, Tenant #5 began entering Tenant #9's apartment. Tenant #5 was found by Tenant #9 two to three times entering Tenant #9's apartment without permission and messing around in the apartment kitchen. Tenant #9 reported Tenant #5 would often come up behind him/her in the hallways. Tenant #9 used a wheelchair. Tenant #5 would begin pushing Tenant #9 without his/her permission and take the wheelchair in whatever direction Tenant #5 felt like. Tenant #9 indicated this scared him/her. Tenant #9 now reported he/she keeps the apartment door shut and locked to prevent Tenant #5 from entering uninvited. The Director reportedly told Tenant #9 there was no need to be fearful and reportedly did nothing to prevent Tenant #5 from intruding on Tenant #9.

During interview, Tenant #10 reported being fearful of Tenant #5. Tenant #10 reported finding Tenant #5 sleeping in Tenant #10's bed on multiple occasions. Tenant #10 reported Tenant #5 would come up behind tenants using wheelchairs in the hallways and would begin pushing them without consent. Tenant #10 reported he/she now kept the apartment door shut and locked to prevent Tenant #5 from entering uninvited.

Tenant #5 was intrusive, entering other tenant apartments without permission on multiple occasions and being physically aggressive with Tenants #2 and #4. Tenant #5's intrusiveness caused Tenants #2, #7, #8, #9 and #10 to be fearful of him/her and required each to keep their apartment doors shut and locked to avoid contact with Tenant #5. Tenant #5 was pushing other tenants in their wheelchairs without consent, causing the other tenants to fear Tenant #5. Tenants #2, #7, #8, #9 and #10's rights were violated by Tenant #5's intrusiveness and physical aggression.

- Regulatory Insufficiency: All tenants have the right to be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481-67.3(1))

- Regulatory Insufficiency: All tenants have the right to receive from the manager and staff of the program a reasonable response to all requests. (IAC r. 481-67.3(5))

The monitors identified the following during the course of the investigation:

B. Criteria for Admission and Retention

- Monitoring Observation: Tenant #5, a 67 year old, was admitted by the program on 5-15-13. Tenant #5 had diagnoses of Mixed Alzheimer's Type and Vascular Type Dementia with Behavioral Components, Major Depression Disorder with Moderate Psychotic Features, Generalized Anxiety Disease, Hallucinations/Delusions, Diabetes and HTN. Tenant #5 scored a 5 on the GDS completed on 8-14-13, indicating moderately severe cognitive decline.

According to Tenant #5's service plans, dated 5-23-13, 6-14-13 and 8-14-13, Tenant #5 communicated with one word sentences, often answering questions with words "junk" or "puppies". Tenant #5 was tall and had a flat facial affect. Tenant #5 wandered around the program, at times entering others apartments or attempting to exit seek.

Prior to moving to the program on 5-13-13, Tenant #5 resided at another assisted living program in a secured dementia unit. The program had all exit doors located within the unit secured. The program's secured dementia unit had four exit doors, three exiting into an enclosed courtyard and one exiting into the general population area of the building. All four doors were secured, preventing unauthorized exiting from the unit. Each door had a keypad that could be used by staff members to bypass the secure system by putting in a common code. Each door had a 15 second egress bar.

When the egress bar was pushed, an alarm sounded notifying staff members of a potential unauthorized exit from the unit. With continuous pressure on the bar for 15 seconds the alarm continued to sound and the door would release allowing exit through the door. Tenant #5 wandered throughout the secured dementia unit while residing at the previous assisted living program. Tenant #5 often repeatedly pushed on the egress bars of the doors exiting into the enclosed courtyard and into the general population area of the building. Tenant #5 exhibited exit-seeking behaviors and repeatedly pushed on the egress bars of the doors exiting into the enclosed courtyard, often times pushing on the bar for 15 seconds, releasing the lock and allowing exit from the building.

Tenant #5 eloped from the previous assisted living on one occasion and was wandering around the community for approximately 45 minutes before staff members were able to locate Tenant #5. Following the elopement, Tenant #5 continued to exit seek, often getting the secured doors to disengage by pushing on the egress bars for 15 seconds. Tenant #5 became agitated and combative when attempts at redirection were made by staff members when Tenant #5 was exit-seeking. Tenant #5 was determined to exceed the level of care allowable for an assisted living during an on-site elopement investigation by the Department of Inspections and Appeals. The other assisted living program gave Tenant #5's legal representative an involuntary 30-day notice to discharge from the program following the March 21, 2013 on-site investigation citing behavioral reasons for the discharge.

According to the Discharge Summary, dated 5-15-13, Tenant #5 was sent to a behavioral medicine unit for psychiatric evaluation and treatment on 4-24-13. According to the Initial Diagnostic Evaluation, dated 4-24-13, Tenant #5 had previously been residing at an assisted living program when he/she began exhibiting progressive exit-seeking behaviors. Tenant #5 attempted to kick in a door in an exit-seeking attempt and had become progressively aggressive, once putting a staff member in a head lock. Tenant #5 had been exhibiting sun downing behaviors (showing increased behaviors of exit-seeking and aggression in the late afternoon/early evening hours).

Tenant #5 had been hitting and kicking at staff members of the assisted living, had been difficult to redirect and had been exhibiting paranoia, hallucinations and delusions. Tenant #5 had a seizure and questionable stroke while at the behavioral medicine unit. Tenant #5 was transferred to a medical/surgical unit at the local hospital. Tenant #5 appeared to be in a coma; therefore, Tenant #5 was transferred to a local nursing home on 4-30-13 with plans to admit to hospice services. While at the nursing home, Tenant #5 awoke from the coma and became agitated and combative with nursing home staff members. Tenant #5 was returned to the behavioral medicine unit the following day on 5-1-13 due to Tenant #5's "considerable cognitive impairment and inadequate treatment during the previous admission to the behavioral unit." The Initial Evaluation, dated 5-1-13, indicated a plan to get Tenant #5 adequately medicated with a planned return to the above stated local nursing home. Tenant #5 was determined to be appropriate for "nursing home level of care" on 5-15-13.

During interview, the Director of Nursing at the nursing home where Tenant #5 had been sent on 4-30-13 reported Tenant #5 had been admitted to the nursing home for one day. Tenant #5 became agitated and combative with nursing home staff members so was immediately sent back out to the behavioral medicine unit. When Tenant #5 was to be discharged from the behavioral unit, the nursing home declined Tenant #5's return due to his/her aggressiveness.

According to Bickford Cottage nurse notes, the program RN visited Tenant #5 at the behavioral medicine unit on 5-9-13 to evaluate Tenant #5's health, functional and cognitive status. On 5-13-13, Tenant #5 legal representative signed the occupancy agreement at Bickford Cottage and Tenant #5 was taken by a private car accompanied by his/her family on 5-15-13 for admission.

During interview, the program's RN reported she was aware that Tenant #5 had resided in another assisted living prior to going to the behavioral medicine unit. The program RN indicated Tenant #5's legal representative reported Tenant #5 had been left unsupervised while outside with staff members and had wandered off from the area. The program RN reported she "did not look at that as being an elopement as staff members left the tenant unattended." The program RN reported she had never contacted the previous assisted living program to determine what Tenant #5 was like there and why he/she had not returned to the program following his/her stay at the behavioral unit.

Tenant #5 moved into the program on 5-15-13. The program is dementia-specific by definition, requiring all exit doors to be secured and alarmed. The program had multiple exit doors leading to unsecured areas outside the building. Each door was locked and required a code to be entered to release the door lock. Each door had a 15 second emergency egress bar that would sound audibly when pushed for 15 seconds then disengage the lock to allow free access from the building.

According to a Staff Notification of New Resident, dated 5-15-13, staff members were alerted that Tenant #5 was moving into the program on 5-15-13. Tenant #5 could at times become agitated and had a history of exit-seeking behaviors.

According to nurse notes, dated 5-15-13, Bickford Cottage initiated private duty one-on-one care after supper until bedtime for Tenant #5 "to assist with an easier transition". Tenant #5's legal representative agreed to pay for the private duty services separately from the assisted living fees. On 5-23-13, the program RN reevaluated the private duty one-on-one companion need, determining the need to continue with the service.

According to the May 2013 medication administration records (MARs), Tenant #5 had a physician's order for Olanzapine, an antipsychotic medication, 5 milligrams (mg) every two hours as needed for anxiety/agitation and Lorazepam 0.5 mg every two hours as needed for anxiety. Tenant #5 was administered the Olanzapine twice on 5-26-13, Lorazepam, an antianxiety medication, once on 5-27-13 and 5-28-13, Lorazepam twice and Olanzapine once on 5-29-13 and 5-31-13 for restlessness and anxiety.

The Nurse Review, dated 6-14-13, indicated Tenant #5 had at times become agitated and redirected poorly. Staff had been directed to administer as needed Lorazepam or Olanzapine when unable to redirect Tenant #5.

The Nurse Review, dated 6-19-13, indicated Tenant #5 continued to at times become agitated and redirected poorly. Tenant #5 had begun exhibiting exit-seeking behaviors with agitation toward staff members with redirection attempts. On 6-18-13 Tenant #5 attempted to exit the program through the main entrance. When staff members attempted to redirect, Tenant #5 swung a non-electric sweeper at staff members in an attempt to hit the staff member. When other staff members attempted to assist, Tenant #5 swung a coat at those staff members. An appointment was made for Tenant #5 to visit his/her physician.

According to nurse notes, dated 6-28-13, Tenant #5 met with his/her physician with no medication changes.

According to the June and July 2013 MARs, Tenant #5 was administered Lorazepam one to two times almost daily for agitation and Olanzapine one to two times almost daily for agitation.

According to the Physician Visit note, dated 7-10-13, Tenant #5 had been exhibiting periods of increased agitation with poor redirection. Tenant #5 had been exhibiting exit-seeking behaviors with one exit attempt on 6-18-13 by which Tenant #5 attempted to push the staff member into the handle of the door with attempted redirection and was swatting at staff members who attempted to assist the first staff member.

A referral was made to another physician. Tenant #5 visited the other physician on 7-17-13. According to the physician's order, dated 7-17-13, the Lorazepam as needed frequency was changed to every 12 hours for severe agitation and the Olanzapine as needed frequency was changed to every 8 hours for severe agitation.

According to nurse notes, dated 7-23-13, Tenant #5 became very agitated with the one-on-one private duty staff member. Tenant #5 pushed on the egress bar and exited to the outside area. Tenant #5 was difficult to redirect requiring multiple staff members to assist with bringing Tenant #5 back into the building. A message was left for Tenant #5's physician. Tenant #5's physician increased one of Tenant #5's routine psychiatric medications.

According to the July 2013 MAR after 7-17-13, Tenant #5 continued to be administered Lorazepam one to two times almost daily and Olanzapine one to two times almost daily.

According to the Nurse Review, dated 8-14-13, Tenant #5's exit-seeking behaviors and agitation had decreased; thereby, the RN changed Tenant #5's need for a one-on-one private duty companion to as needed rather than every evening.

According to the August and September 2013 MARs, Tenant #5 continued to be administered Olanzapine one to two times almost daily.

According to an incident report, dated 10-1-13, Tenant #5 pushed Tenant #2, causing both to fall to the floor, resulting in Tenant #5 fracturing his/her clavicle. Tenant #2 suffered no injuries. According to an incident report, dated 10-9-13, Tenant #5 pushed Tenant #4 while walking in the enclosed courtyard. Tenant #4 did not fall or receive any injuries. The program immediately sent Tenant #5 to the emergency room for psychological evaluation and Tenant #5 had not returned to the program during the on-site visit.

During interview, Staff #1, Licensed Practical Nurse (LPN) reported Tenant #5 had been exit-seeking since admission to the program. Tenant #5 reportedly pushed on the egress bars of exit doors multiple times daily, would go out the doors after the egress released the door lock and staff members would have to redirect Tenant #5 back into the building. Tenant #5 was most times easily directed. Tenant #5 was administered Olanzapine and Lorazepam on an as needed basis to in an attempt to decrease exit-seeking behaviors and combativeness. Staff #1 reported a belief that Tenant #5 exceeded assisted living level of care shortly after admission to the program and continued to exceed level of care until present. Staff #1 reported being fearful of Tenant #5 as he/she was "tall, had a flat facial affect and was never sure what Tenant #5 might do."

During interview, Staff #2, certified nursing assistant (CNA) reported she was initially afraid of Tenant #5 but then became more used to him/her. Tenant #5 had been exit-seeking since admission to the program. Tenant #5 reportedly pushed on the egress bars of exit doors multiple times daily, would go out the doors after the egress released the door lock and staff members would have to redirect Tenant #5 back into the building. Tenant #5 was most times easily directed but at times was more difficult to redirect. Tenant #5 frequently entered other tenant apartments uninvited.

During interview, Staff #3, certified medication aide (CMA) reported Tenant #5 had been exit-seeking since admission to the program. Tenant #5 reportedly pushed on the egress bars of exit doors multiple times daily, would go out the doors after the egress released the door lock and staff members would have to redirect Tenant #5 back into the building. Tenant #5 was hard to direct on a daily basis. Tenant #5 was administered Olanzapine and Lorazepam on an as needed basis to in an attempt to decrease exit-seeking behaviors and combativeness. Staff #3 reported a belief that Tenant #5 exceeded assisted living level of care shortly after admission to the program and continued to exceed level of care until present. Staff #3 reported being fearful of Tenant #5 as he/she had a blank stare, would get up close to others, and break out in a sweat before becoming agitated.

During interview, Tenant #2 reported being afraid of Tenant #5. Tenant #2 reported Tenant #2 jumped on his/her back on 10-1-13 and both ended up on the ground. Tenant #2 reported he punched Tenant #5 while they were wrestling around in an attempt to get Tenant #5 off of him/her. Tenant #2 reported a previous occasion when Tenant #5 shoved Tenant #2 up against the hallway wall for no apparent reason. Tenant #2 reported he would often go to his/her apartment, close and lock the door when seeing Tenant #5 wandering the hallways.

During interview, Tenant #7 reported being fearful of Tenant #5. Tenant #7 reported Tenant #5 would walk up behind him/her at lunch on occasion and had entered Tenant #7's apartment and lay down on the bed to sleep about two to four weeks prior to the on-site visit. Tenant #7 reported he/she now kept the apartment door closed and locked to keep Tenant #5 away. Tenant #7 reported preferring to leave the door ajar for fresh air but doing so would allow Tenant #5 to enter uninvited.

During interview, Tenant #8 reported being afraid of Tenant #5. Tenant #8 reported at first Tenant #5 had a staff member one-on-one at all times. Sometime after admission, the one-on-one caregiver was removed. At this time, Tenant #5 began entering Tenant #8's apartment. Tenant #5 was found by Tenant #8 two to three times entering Tenant #8's apartment without permission and messing around in the apartment kitchen. Tenant #8 reported Tenant #5 would often come up behind Tenant #8's spouse in the hallways. Tenant #8's spouse used a wheelchair. Tenant #5 would begin pushing Tenant #8's spouse without his/her permission and take the wheelchair in whatever direction Tenant #5 felt like. Tenant #8 indicated this scared his/her spouse.

Tenant #8 now reported he/she keeps the apartment door shut and locked to prevent Tenant #5 from entering uninvited. Tenant #8 reported telling the Director of the program. The Director reportedly told Tenant #8 there was no need to be fearful and reportedly did nothing to prevent Tenant #5 from intruding on Tenant #8.

During interview, Tenant #9 reported being afraid of Tenant #5. Tenant #9 reported at first Tenant #5 had a staff member one-on-one at all times. Sometime after admission, the one-on-one caregiver was removed. At this time, Tenant #5 began entering Tenant #9's apartment. Tenant #5 was found by Tenant #9 two to three times entering Tenant #9's apartment without permission and messing around in the apartment kitchen. Tenant #9 reported Tenant #5 would often come up behind him/her in the hallways. Tenant #9 used a wheelchair. Tenant #5 would begin pushing Tenant #9 without his/her permission and take the wheelchair in whatever direction Tenant #5 felt like. Tenant #9 indicated this scared him/her. Tenant #9 now reported he/she keeps the apartment door shut and locked to prevent Tenant #5 from entering uninvited. The Director reportedly told Tenant #9 there was no need to be fearful and reportedly did nothing to prevent Tenant #5 from intruding on Tenant #9.

During interview, Tenant #10 reported being fearful of Tenant #5. Tenant #10 reported finding Tenant #5 sleeping in Tenant #10's bed on multiple occasions. Tenant #10 reported Tenant #5 would come up behind tenants using wheelchairs in the hallways and would begin pushing them without consent. Tenant #10 reported he/she now kept the apartment door shut and locked to prevent Tenant #5 from entering uninvited.

Tenant #5 was previously determined to exceed the assisted living level of care while residing at a previous assisted living program due to Tenant #5's elopement with continued exit-seeking behaviors and Tenant #5's aggressive behavior with staff members when redirection was attempted. Bickford Cottage admitted Tenant #5 without checking with the previous assisted living to determine Tenant #5's behaviors while residing there. Tenant #5 continued to exhibit exit-seeking behaviors multiple times almost daily. Tenant #5 continued to exhibit agitation with redirection, requiring administration of two as needed psychiatric medications on an almost daily basis to decrease the behaviors. Tenant #5 was intrusive, entering other tenant apartments without permission on multiple occasions and being physically aggressive with Tenants #2 and #4. Tenant #5's intrusiveness caused Tenants #2, #7, #8, #9 and #10 to be fearful of him/her. Tenant #5 was pushing other tenants in their wheelchairs without consent, causing the other tenants to fear Tenant #5. The program used a one-on-one private duty companion to better supervise Tenant #5 due to the multiple exit-seeking attempts and progressively increasing agitated behaviors. Tenant #5 continued to exceed assisted living level of care.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: a. Is bed-bound; or b. Requires routine, two-person assistance with standing, transfer or evacuation; or c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually aggressive or abusive, or displays unmanageable verbal abuse or aggression; or (2) Displays behavior that places another tenant at risk; or d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; or e. Is under the age of 18; or f. Requires more than part-time intermittent health related care; or g. Has unmanageable incontinence on a routine basis despite an individualized toileting program; or h. Is medically unstable; or i. Requires maximal assistance with activities of daily living. (IAC r. 481-69.23(1)c(1)(2))