IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
45965-I
46113-I

December 27, 2013

Ms. Laura Brock, Director
Bickford Cottage Davenport
4040 East 55th Street
Davenport, IA 52807

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

Dear Ms. Brock:

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 Insufficiency, 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

Enclosure

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

Assisted Living Program:

Laura Brock, Director
Bickford Cottage Davenport
4040 East 55th Street
Davenport, IA 52807

Complaint/Incident Intake #: 45965-I, 46113-I

Date of Complaint/Incident Investigation:

November 18 & 19, 2013

Monitor(s):

Margaret Kaltefleiter, RN MS

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 69 that serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to and approved by the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	26
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	30
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	7
TOTAL census of Assisted Living Program	37

Program History – The program received regulatory insufficiencies during this certification period in the area of Dementia Specific Education, Tenant Rights and Service Plans.

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

A. Policies and Procedures

Complaint/Incident Allegation #46113-I: The Program reported Tenant #1 was missing $20.00.

- Monitoring Observation: Three tenant files were reviewed.

  Tenant #1, a 64 year old, was admitted on 1-9-12 and diagnoses included: Cerebral Palsy. Tenant #1 stated Tenant #1 always kept Tenant #1's wallet in a backpack that hung on the back of Tenant #1's wheelchair. The backpack was unzipped at all times. Tenant #1 stated maybe between four and six staff knew Tenant #1 had a wallet but Tenant #1 didn't have any suspects as to who might have taken the money. Tenant #1 ate most of Tenant #1's meals in the apartment. Tenant #1 stated 99% of the time staff stayed with Tenant #1 in the bathroom but sometimes Tenant #1 told staff Tenant #1 needed to be alone so staff left the apartment and Tenant #1 called staff back when needed. Tenant #1 stated about two weeks ago, Tenant #1 had one twenty dollar bill and a single one dollar bill in Tenant #1's wallet. Tenant #1's Private Caregiver stopped by to bring Tenant #1 some coffee and Tenant #1 wanted to reimburse the Private Caregiver. The Private Caregiver took out the wallet and there was one twenty dollar bill and a single one dollar bill. Tenant #1 was not able to make change for the coffee purchase so the Private Caregiver stated she would wait until she returned in two days to be paid.

Two days later when the Private Caregiver accessed the wallet, the only dollar bills found were two one dollar bills. Thus, Tenant #1 stated only $19.00 was missing. Tenant #1's family member brought cash to Tenant #1. Tenant #1 stated about six to eight weeks previously Tenant #1 had $40.00 missing. At the time Tenant #1 thought it was a misunderstanding of the actual amount of money Tenant #1 had. Tenant #1 talked to Tenant #1's family member and the family member could not remember whether the amount was $80.00 or $40.00 that had been given to Tenant #1. Now Tenant #1 thinks possibly there was $80.00, thus $40.00 would have been taken. At the time of the investigation Tenant #1 stated no further items had been missing.

The Private Caregiver stated on a Thursday she had gotten iced coffee for Tenant #1 and decided to bring it to Tenant #1 because it was Halloween. The cost of the coffee was $5.00. The only money Tenant #1 had was a twenty dollar bill and a one dollar bill. Since she couldn't make change for the $20.00, she told Tenant #1 she would wait until Saturday to get paid. On Saturday she came into work at 7:45 a.m. About 8:30 a.m. she went into Tenant #1's wallet to get out a coffee gift card to buy Tenant #1 some coffee. At that time she saw there were two one dollar bills in the wallet. She asked Tenant #1 if Tenant #1 had spent the money and Tenant #1 responded, "No, no, no." She took everything out of the wallet to look for the $20.00 bill and it wasn't there. She looked in the backpack which was always on the back of the wheelchair and unzipped. The backpack contained a cell phone and little things from church and a bag with straws. A month or two earlier, Tenant #1 wanted her to put $40.00 on a coffee gift card and to take an additional $20.00 to buy Tenant #1's lunch but when she looked in the wallet there was only $40.00. Tenant #1 thought there was $80.00 so Tenant #1 talked with Tenant #1's family member who wasn't sure how much money the family member had gotten for Tenant #1. Tenant #1 wasn't upset at that time as Tenant #1 thought it was a miscommunication with Tenant #1's family member. The Private Caregiver left a note for the Program's Director and notified her employer of the incident.

Staff #1 stated she was working on Saturday morning when a Private Caregiver came in and told her that Tenant #1 wanted to talk to her. The Private Caregiver stated she had been there on Thursday and Tenant #1 had $20.00 in a wallet and now it was not there. Tenant #1 was upset someone had taken the money. Staff #1 called the Director and put a note written by the Private Caregiver under the door to the Director's office. Staff #1 knew Tenant #1 had a wallet in the backpack on the back of the wheel chair. A phone was kept in the backpack as well as a charger, a blue tooth and weights. Staff #1 stated she was not aware of any other tenants missing money.

Staff #2 stated the Director asked her if she knew Tenant #1 had money in a wallet. Staff #2 stated she knew Tenant #1 had a wallet but didn't know Tenant #1 had any money in the wallet. Tenant #1 kept a cell phone and blue tooth in a backpack along with arm weights. Staff #2 normally transferred Tenant #1 to a wheel chair or the toilet. Staff #2 stated she was not aware of any other tenants have any missing items.

Staff #3 stated the Director reported money was missing. Staff #3 had worked the day shift on Thursday and the evening shift on Friday and provided a written statement about working with Tenant #1. Staff #3 stated Tenant #1 had a wallet that was always in a backpack along with a cell phone. Staff #3 only looked in the backpack when Tenant #1 asked her to get something out of it. She would go into the backpack when Tenant #1 went to bed to get the phone out and put it into the phone charger on the bedside table. She would also put the blue tooth in a charger. The backpack was always unzipped and hung on the wheel chair handles on the back side of the wheel chair.

The Registered Nurse Coordinator (RNC) stated the Director was doing an investigation and asked her if she knew Tenant #1 had money. She stated she had no idea if Tenant #1 did or did not. She was not involved with anything else regarding the situation.

The Director stated on 11-2-13 a staff called and said Tenant #1 was missing some money. A note was left by the Private Caregiver indicating she had been there on Thursday and the money was there and now it was gone. The Director spoke to Tenant #1 who kept a backpack on a motorized scooter. Tenant #1 kept money in a wallet in a backpack. The backpack was always in view except when Tenant #1 was sleeping or in the bathroom. The Director stated she interviewed all staff that worked from Thursday through Saturday. Tenant #1 indicated sometime earlier Tenant #1 thought Tenant #1 had $40.00 but didn't think it was stolen but now thought maybe it was stolen. The Director stated she asked her Divisional if she could set up a recording but Human Resources said they could not video staff in tenant apartments. The Director stated she arranged an in-service on theft to be held on 11-26-13 that would be presented by a police department.

A review of incident reports was completed. An incident report was not found regarding Tenant #1's report of missing money. The Director stated an incident report had not been completed. A review of Tenant #1's file indicated lack of documentation in the Tenant Progress Notes regarding Tenant #1's report of missing money.

The Incident and Accident Report Policy indicated incidents or accidents would be documented immediately following the occurrence. The person in charge at the time of the incident or accident would prepare and sign the report. Any incident also needed to be documented in the Tenant Progress Notes.

The Program reported the incident to the Department.

Review of incident reports, policy review, Tenant #1's file review, an interview with Tenant #1, staff interviews and Director interview was completed. The Program did not complete an incident report regarding the missing money and did not document the incident in the Tenant Progress Notes. The Program did not follow the policies and procedures established by the Program.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2))

B. Other

Complaint/Incident Allegation #45965-I : The Program reported Tenant #2 had fallen and suffered a head injury.

- Monitoring Observation: Three tenant files were reviewed.

Tenant #2, a 96 year old, was admitted on 9-10-12 and diagnoses included: Dementia, Legally Blind, Hypertension, Hard of Hearing, Osteoporosis, Hypercholesterolemia, Esophageal Reflux and Dysthymic Disorder. Tenant #2 was staged at a five on the Global Deterioration Scale which indicated moderately severe cognitive decline. Tenant #2 resided in the dementia unit. According to an Incident Report dated 10-21-13 at 3:40 p.m., Tenant #2 was walking around the living room area watching Staff #4 in the kitchen area. Tenant #2 lost balance and fell backwards, hitting head on a wooden chair. Staff #4 called up front for assistance. The RNC, Director and a staff came back to assist. The RNC advised to call 911. A staff called 911 and Tenant #2 was sent to the Emergency Room (ER). Vital signs were recorded as blood pressure 130/70, pulse 84, respirations 20 and temperature 97.2. Tenant #2's physician and family were notified. Documentation by the RNC indicated Tenant #2 was sent to the ER via medic for evaluation of laceration to back of head and pain in neck and left shoulder.

According to a Service Plan dated 10-2-13, Tenant #2 was independent with mobility within the dementia unit and staff would provide stand by assistance when ambulating outside of the dementia unit. According to Progress Notes dated 10-21-13, at 3:40 p.m. Staff #4 indicated Tenant #2 was walking around the living room area and watching Staff #4 in the kitchen area. Tenant #2 lost Tenant #2's balance and fell backwards hitting head on a wooden chair. Staff #4 called up front for assistance. The RNC, Director, and staff came back to assist. The RNC advised to call 911. A staff called 911 and Tenant #2 was sent out to the ER. According to Progress Notes dated 10-21-13 the RNC indicated she was called back to the dementia unit for a fall. Tenant #2 was lying on the floor and staff reported Tenant #2 had hit head. The RNC had staff help carefully; put Tenant #2 into a position on right side so the RNC could attempt to look at the back of head after she noticed a large amount of blood on the carpet. When they attempted to put Tenant #2 on back again, Tenant #2 screamed in pain and grabbed the left side of neck. Staff supported Tenant #2 while still lying on side; held pressure to head wound and called 911 for transport to the ER. Medics arrived and took Tenant #2 to the ER for evaluation. Tenant #2's family was aware and would meet Tenant #2 at the ER. Tenant #2's physicians' office was notified.

According to the Progress Notes dated 10-22-13, the RNC spoke with the ER physician the previous night who told her Tenant #2 had an unstable cervical fracture and would be transferred to another hospital for treatment. On 10-22-13 at 10:30 a.m. the RNC spoke with Tenant #2's family who indicated the family was unsure about discharge plans or treatment options but the discussion with Tenant #2's physicians indicated Tenant #2 was not a good surgical candidate and Tenant #2 would be discharged with a collar. At 10:45 a.m. the RNC spoke with the nurse caring for Tenant #2 who stated Tenant #2 was currently on bed rest and was to have no unnecessary movement. The nurse was unaware of any treatment plans or discharge plans at that time.

Staff #4 stated she was in the kitchen making drinks and Tenant #2 was walking back and forth. Staff #4 waved at Tenant #2 one time and the next thing she knew she heard a noise, looked and saw Tenant #2 falling backwards onto the floor. The floor was clear of debris. Tenant #2 hit a chair with the back of head on the way down to the floor. There was a visitor sitting in a chair with the visitor's feet on the floor and Tenant #2 landed on the visitor's feet and Tenant #2's head went under the rungs on the chair. Staff #4 called for assistance and the RNC and Director arrived and assessed the situation. The RNC saw blood on the floor beneath Tenant #2's head and Tenant #2 was moaning. Staff #4 called 911 and medics arrived and Staff #4 left. Staff #4 stated Tenant #2 was independent in ambulation and did not use any assistive devices.

Staff #2 stated she would cover breaks in the dementia unit and at times would bring Tenant #2 up front for activities, exercises, music and crafts. Tenant #2 did not use any assistive devices. Staff #2 was off work on the day of Tenant #2's fall and it was the first fall Tenant #2 had of which Staff #2 was aware.

Staff #3 stated Tenant #2 walked independently. Staff #3 rarely worked in the dementia unit but did cover breaks in the unit.

The RNC stated she was called to the dementia unit for a fall and found Tenant #2 lying on back by the entrance to the kitchen. Tenant #2's feet were towards the kitchen doors and head was under the rungs on a kitchen chair. She tried to assess the head and neck area and noticed an area approximately four inches around of blood on the carpet under Tenant #2's head. The RNC asked for assistance of two staff to log roll Tenant #2 onto Tenant #2's side. The occipital area behind the right ear was the injured area. She started to roll Tenant #2 onto Tenant #2's back but Tenant #2 complained of pain. Tenant #2 put Tenant #2's hand up to right side of Tenant #2's neck. Staff propped Tenant #2 to where Tenant #2 was most comfortable and there was no active bleeding. A call was made to 911. The RNC covered the affected area with gauze and applied pressure while waiting for the medics. The medics arrived and took over the cares, attempted to obtain vital signs, applied a C collar and attempted to assess. Tenant #2 was blind and hard of hearing so it was difficult to assess neurological checks. Later the RNC called the ER and a physician answered and said Tenant #2 had a non-stable cervical fracture and Tenant #2 was transferred to another hospital.

Later Tenant #2's family called to see if Tenant #2 could return but she told them she would need to complete an assessment. She then called the hospital and was told they were not looking at discharge. Tenant #2 was sedated and on intravenous pain medications and was not to be moved. The RNC stated Tenant #2 did not use assistive devices and was independent in ambulation. The RNC said Tenant #2 was just standing when the fall occurred and wasn't really walking.

The Director was interviewed and stated Staff #4 called up front, needed help and needed the nurse. The Director went to the dementia unit and saw Tenant #2 was lying on back, head near the front of a chair and was hollering. The RNC used a flashlight to see Tenant #2's wound and could only see blood. A call was made to 911 and the Director called Tenant #2's family. Medics arrived and placed a collar on Tenant #2's neck, placed Tenant #2 on a back board and went to the hospital. Staff #4 completed an incident report. The Director stated Tenant #2 had been talking while standing and then fell onto back. Tenant #2 was independent in ambulation and staff walked with Tenant #2 when outside of the dementia unit due to Tenant #2's limited vision. Tenant #2 came to daily exercises in the general population. Tenant #2 got up on own, was independent in toileting, enjoyed playing cards, had a journal and would write letters. The Director stated Tenant #2 passed away at the hospital on 10-29-13.

A fax from the county medical Examiner's Department indicated Tenant #2 passed away on 10-29-13 at 10:17 a.m.

The Program notified the Department and completed an incident report.

Review of Tenant #2's file, incident report, staff interviews and interviews with the Nurse and Director indicated Tenant #2 was independent in ambulation, had a fall and suffered a head injury.

- Regulatory Insufficiency: None noted.