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 #:
46111-C

January 13, 2014

Ms. Jill Colling, Director
Bickford Cottage I Assisted Living
4020 Indian Hills
Sioux City, Ia 51104

RE: Final Complaint/Incident Investigation Report, Bickford Cottage I Assisted Living, 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.

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

Enclosure

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

Assisted Living Program: **Complaint/Incident Intake #: 46111-C**

Jill Colling, Director
Bickford Cottage 1 Assisted Living
4020 Indian Hills
Sioux City, IA 51104

Date of Complaint/Incident Investigation:

December 9, 10, and 11, 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.

<u>Overview</u>: *In preparing this report, the following information was considered:*

<u>Current Program Census</u>

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:	22
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	22
TOTAL census of Assisted Living Program	22

<u>Program History</u> – The program received regulatory insufficiencies in the areas of Staffing and Program Reporting during the recertification period.

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

A. Staffing

<u>Complaint/Incident Allegation</u>: It was alleged a tenant was "dropped" resulting in fractures.

- <u>Monitoring Observation</u>: The program was asked to provide incident reports that dated 6-1-13 to current date. The program provided 19 incident reports to the monitor. Three reported incidents involving staff members only. One reported a tenant hit the head against a door accidentally; the remainder identified tenants found on the floor most often after staff members were summoned. Three files were selected for review from the list of incident reports.

  Tenant #1, a 98 year-old, was admitted on 7-19-10 and had diagnoses of: Atrial Fibrillation and History of Urinary Tract Infection (UTI). Tenant #1 was staged at three on the Global Deterioration Scale which indicated mild cognitive decline.

  Tenant #1 had the following incident reports:

  9-22-13 timed 9:45 p.m. reported Tenant #1 used the call light. A staff member found Tenant #1 lying on the floor next to the bed. No injuries were identified. According to the progress notes written by the Registered Nurse (RN), Tenant #1 was suspected of having a UTI and was seen in the emergency room and returned with orders for antibiotics for a urinary tract infection.

11-9-13 timed 11:10 p.m. reported Tenant #1 was transferring self into a wheelchair from the bed. The wheelchair was not locked and Tenant #1 fell between the bed and wheelchair. The spouse tried to assist without success. The bed alarm sounded. Tenant #1 was observed to have a small cut on both arms.

12-6-13 timed 7:00 p.m. reported a staff member responded to a call light. Tenant #1 was found sitting on the floor. The spouse was present. No injuries were identified.

According to an entry in the progress notes completed by the RN, Tenant #1 did not always call for assistance and bed and chair alarms were in use. During the onsite visit, Tenant #1 was observed in the dining room in a wheelchair with a chair alarm in place.

Tenant #1 had a current service plan dated 9-17-13 which indicated Tenant #1 required assistance with transfers in and out of bed and self-transferred to the toilet. The service plan identified the use of bed and chair alarms.

Tenant #2, a 97 year-old, was admitted on 12-16-11 and had diagnoses of: History of Right Hip Fracture, Hypothyroidism, Hypertension, Peripheral Neuropathy, Osteoporosis, and Chronic Depression. Tenant #2 scored 30 of 30 on the Mini Mental State Examination (MMSE) on 4-14-13 which indicated intact intellectual functioning.

According to progress notes completed by the RN, Tenant #2 had completed a course of antibiotic for a UTI on 7-1-13. On 7-1-13, Tenant #2 complained of Right Lower Back Pain, with an unknown cause. The notes documented Tenant #2 had no falls, but Tenant #2 had participated in exercise the week prior which is when the discomfort to the right lower back started. The physician was notified. Progress notes dated 7-2-13 indicated Tenant #2 was seen by the physician and X-Rays were taken. The progress notes documented Tenant #2 had a history of an old back injury. The progress notes documented Tenant #2 was to call for assistance with transfers and ambulation.

Tenant #2 had the following incident report and documentation:

Incident report dated 7-6-13 and timed 8:30 a.m. completed by Temporary Staff #1 which indicated Tenant #2 was walking to the bathroom when legs gave out and Tenant #2 was eased to the floor. A gait belt was used. Tenant #2 was taken to the hospital via ambulance.

In documentation from the hospital, the X-Rays of 7-2-13 were compared with studies completed after hospitalization, changes were seen. Tenant #2 had acute and sub-acute fractures in the lumbar spine.

Incident report dated 7-6-13 and timed 8:15 a.m. completed by Staff #2 which stated Staff #2 was contacted by Temporary Staff #1 and indicated Temporary Staff #1 and Tenant #2 were both on the floor. Temporary Staff #1 stated Tenant #2's legs went out and both went down.

Tenant #2 complained of the back hurting and Temporary Staff #1 stated her back was hurting and "popped." The incident report documented Tenant #2 was assisted to the bathroom with assist of three persons. Tenant #2 complained of more back and leg pain.

A fax dated 7-8-13 from the Temporary Staffing Agency included a statement which indicated Temporary Staff #1 was in the dining room when she was notified by another staff person that Tenant #2 needed to use the bathroom. Temporary Staff #1 put a gait belt on Tenant #2 and both started walking to the bathroom. Tenant #2 "just dropped" his/her weight and Temporary Staff #1 eased Tenant #2 to the floor. Temporary Staff #1 pulled the call light to request help. Staff #2 arrived and Temporary Staff #1 stated she was unable to get Tenant #2 up. Temporary Staff #1 reported Staff #2 went to get the cook to help get Tenant #2 off the floor. Tenant #2 was gotten off the floor, walked to the bathroom with staff assistance, and then returned Tenant #2 to the chair. According to the documentation, Staff #2 went to get more help as Staff #2 was pregnant and could not help.

An attempt was made to contact Temporary Staff #1 by phone without success. According to the Temporary Staffing Agency, Temporary Staff #1 no longer works for the agency.

The cook was interviewed. She stated she did remember Tenant #2 being on the floor, but Tenant #2 was already up when the cook arrived. The cook stated one of the staff members was pregnant, which is why the cook was asked to help.

Staff #2 was interviewed. Staff #2 reported Temporary Staff #1 went to Tenant #2's room. Temporary Staff #1 pulled the call light in the bathroom. Staff #2 responded and found both Tenant #2 and Temporary Staff #1 on the floor. Staff #2 asked Temporary Staff #1 what happened. Temporary Staff #1 reported Tenant #2 was on the floor and Temporary Staff #1 tried to help Tenant #2 and both went down. Staff #2 stated Tenant #2 had a history of back pain, but Tenant #2 reported the back pain was worse and legs were hurting. Temporary Staff #1 reported her back "popped" when trying to pick up Tenant #2. Staff #2 checked Tenant #2's range of motion and determined Tenant #2 could move the legs. Tenant #2 reported an urgency to get to the bathroom. Since Temporary Staff #1 had back pain, Staff #2 left the room to get the cook for assistance in helping Tenant #2 up off the floor. Staff #2 reported Tenant #2 had a gait belt on. Staff #2 reported the program does not use gait belts, so Staff #2 thought Temporary Staff #1 must have had one. Staff #2 reported she and the cook used reached under Tenant #2's arms and the back of Tenant #2's pants to get Tenant #2 off the floor. Staff #2 and Temporary Staff #1 stayed with Tenant #2 while Tenant #2 was in the bathroom. Staff #2 reported she asked Tenant #2 about going to the hospital, but Tenant #2 initially said "no" because Tenant #2 did not want family disturbed. Staff #2 asked Tenant #2 about the ability to walk from the bathroom to the chair, and Tenant #2 reported wanting to do so. Staff #2 reported she and Temporary Staff #1 lifted Tenant #2 from the toilet. Staff #2 stated Temporary Staff #1 seemed to be concerned about Staff #2's physical condition. With the assist of two, Tenant #2 was walked to the chair and Tenant #2 sat down. Staff #2 sent Temporary Staff #1 to assist in the dining room. Staff #2 continued to stay with Tenant #2 who refused to be seen at the hospital.

Staff #2 reported Tenant #2 voiced concern over family who had just left town, and was concerned about how to get to the hospital. Staff #2 phoned the RN, and an ambulance was called. Tenant #2 never returned to the program.

Staff #2 reported this was the first time Temporary Staff #1 had been at the program, and that the Temporary Staffing Agency was not used often. Staff #2 reported there were a couple weeks where a few shifts needed to be filled. Staff #2 reported 7-6-13 was a Saturday. Staff #2 arrived at 7:00 a.m. Temporary Staff #1 was already in the building. The night shift had prepared and reviewed with Temporary Staff #1 a list of tenants who needed morning assistance. Staff #2 then went over the list with Temporary Staff #1 as well. Staff #2 served as the medication aide for the day, and Temporary Staff #1 served meals.

After Temporary Staff #1 reported back pain after Tenant #2 was on the floor, Temporary Staff #1 contacted her supervisor and was directed to be seen. Staff #2 contacted her supervisor who arranged for a staff member from the other building on the campus to come to assist for the remainder of the shift.

Staff #2 reported Tenant #2 required assistance with bathing, assistance getting out of bed and getting dressed for the day, and required assistance getting out of dining room chairs because the seats were low. Tenant #2 had back pain for a couple weeks prior to 7-6-13.

The incident report dated 7-6-13 and completed by Temporary Staff #1 contained a notation dated 7- 8-13 and completed by the RN. The notation indicated Tenant #2 was up with Temporary Staff # 1 and was walking with the walker and gait belt. Tenant #2 reported staff let go of the gait belt and Tenant #2 went down on the floor. In an interview with the RN, she stated she saw Tenant #2 in the hospital on 7-8-13.

Tenant #2 was interviewed on 12-10-13. Tenant #2 reported she was walking from the bathroom to the chair with Temporary Staff #1 and Staff #2 on each side. Tenant #2 was identified as saying "catch me" and Temporary Staff #1 let go of Tenant #2. That left Staff #2, who was pregnant, to provide support. Tenant #2 reported Staff #2 was not strong enough to hold Tenant #2 and Tenant #2 landed on the buttocks. Tenant #2 reported a gait belt was not used.

The program schedule was reviewed against a list provided by the Temporary Staffing Agency to determine which temporary staff had worked at the program. The Temporary Staffing Agency list also contained names of persons who had worked at the other building on campus. With the Director and the RN, it was determined Temporary Staff #1 and Temporary Staff #2 had worked at the program since July 2013.

In an interview with the Director, she stated since she began employment with the program, October 2013, the Temporary Staffing Agency has provided staff on three occasions. The Director stated staff from the Temporary Staff Agency were paired with someone "for a little bit" but did not know about any staff training. The Director reported she did not know what training the Temporary Staffing Agency provided.

In an interview with the RN, She stated the Director worked with the Temporary Staffing Agency. The RN expected the agency would send qualified staff members, Certified Nursing Assistants or Medication Aides. The temporary staff members had been instructed to come in early for a shift if they were not comfortable or had any questions. The RN stated she was on call 24/7 for any questions. The RN stated the program does not use gait belts and gait belts require nurse-delegation for use. The RN stated she did not delegate Temporary Staff #1 to use a gait belt nor did Temporary Staff #1 seek direction from the RN prior to use of the gait belt. The program had no documentation of any training for Temporary Staff #1 or #2.

In a phone interview with Temporary Staffing Agency Staff #3, she reported the program did not provide any kind of food safety training and would expect the hiring agency to do so. The agency was asked to provide documentation of training for Temporary Staff #1 and #2 related to the use of gait belts. The agency did not provide any documentation.

The program provided documentation of a staffing pattern of two direct care staff for the day shift. According to the schedule, Temporary Staff #1 and Staff #2 were the two direct care staff scheduled for the day. Staff #2 indicated she phoned the RN on 7-6-13 following Tenant #2's increased complaint of back pain; the RN was not present in the building on Saturday 7-6-13 at the time of the incident with Tenant #2.

Interviews were performed with Staff #3 and #4 and both stated they served meals during their shift. On 12-10-13 observations were made of Staff #3 and #4 in the dining room serving meals.

Tenant #3, an 83 year-old, was admitted on 2-17-13 and had diagnoses of: Diabetes, Atrial Fibrillation, Chronic Kidney Disease, Hypertension, Chronic Obstructive Sleep Apnea, Anemia, Coronary Artery Disease, Gastroesophageal Reflux Disease, and Major Depression. Tenant #3 scored 30 of 30 on the MMSE which indicated intact intellectual functioning.

Tenant #3 had the following incident reports:

6-7-13 timed 7:10 a.m. documented a staff member went to wake Tenant #3 for breakfast. Tenant #3 came out of the bathroom with blood on the nose and hand and reported a fall. There were no other injuries reported. Wound care was provided to the nose, lip, and hands.

11-18-13 timed 12:30 p.m. indicated Tenant #3 accidentally hit the head on a door. A small wound was noted by the left eyebrow which was cleansed and dressed.

The service plan of 6-19-13 revealed Tenant #3 was independent with ambulation and transfers.

The program used temporary agency staff. The staffing pattern on 7-6-13 included the agency staff. The responsibilities during the course of the shift included tenant care and meal service. The program depended on the staffing agency for training of the agency staff. The staffing agency did not provide food safety training.

Temporary Staff #1 reported using a gait belt to transfer Tenant #2. The RN reported the program does not use gait belts, and the use of gait belts was a nurse-delegated task. Neither the program nor the staffing agency provided documentation of training, or documentation of the demonstration of competency.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

B. Program Reporting to the Department

Complaint/Incident Allegation: It was alleged the program did not report the incident to the department.

- Monitoring Observation: Tenant #2 requested assistance for transfer to the bathroom Temporary Staff #1 went to provide assistance. Tenant #2 was on the floor and sustained a back injury. Tenant #2 was transferred to the hospital and never returned to the program.

  A review of the service plan of 4-15-13, current at the time of the injury, indicated Tenant #2 required assistance of one for transfers in and out of bed. Staff members were to assist as need getting out of chairs, or with toileting. The progress notes dated 7-1-13 documented Tenant #2 was to call for assistance with transfers and ambulation.

  Tenant #2 was not independent with ambulation or transfers at the time of the incident of 7-6-13. Tenant #2 was transferred to a higher level of care following a fall. Temporary Staff #1 was in attendance at the time of the fall according to an incident report of 7-6-13. The department did not receive notification of the incident.

  The program should have notified the department of the incident.

- 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: Of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury. (a) "Major injury" shall be defined as any injury which: (2) Requires admission to a higher level of care for treatment, other than for observation. (IAC r. 481-67.4(1)(a)(2))