IOWA DEPARTMENT OF
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Complaint/Incident Intake #:
47555-C

March 31, 2014

Jenniffer Westfall, Director
Bickford Cottage Ames
2418 Kent Avenue
Ames, IA 50010

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

Dear Ms. Westfall:

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, following an investigation by DIA on **March 19, 20, 24 and 25, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Rights, Policies and Procedures, Staffing and Service Plans.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted to DIA within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

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:

Jenniffer Westfall, Director
Bickford Assisted Living
2418 Kent Avenue
Ames, IA 50010

Complaint/Incident Intake #: 47555-C

Date of Complaint/Incident Investigation:

March 19, 20, 24, and 25, 2014.

Monitor(s):

Lori Miner, RN BSN

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

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

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

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

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

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

Current Program Census

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

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	25
Number of tenants with cognitive disorder:	13
Total Population of Program at time of on-site	38
TOTAL census of Assisted Living Program	38

Program History – During the February 11, 2013 Recertification on-site, the program did not receive any regulatory insufficiencies.

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged a staff member gave one tenant's medications to another.

- Monitoring Observation: The program was asked to provide medication error reports for the last three months and provided the following two incident reports:

  A medication error report dated 2-5-14, documented Staff #1 administered a pain medication to a tenant which was being held temporarily. The medication was prescribed to the tenant to whom it was given.

  A medication error report dated 2-12-14 documented Staff #2 administered medications prescribed for another tenant, later determined to be Tenant #1, and administered Tenant #1's medications to Tenant #2. Tenant #2 was given Atorvastatin (an antilipidemic) and Lyrica (used for neuropathic pain) instead of Simvastatin (an antilipidemic) and Tylenol. The medication error report was completed and a fax was sent to the primary physician as notification of the error.

  Staff #2 documented there were two tenants waiting for medicine at 7:00 p.m. The medicine was prepared for one of the tenants. Staff #2 stepped out of the medication room into the hallway, was distracted, and handed the medication to Tenant #2. Staff #2 went back into the medication room to document the medication as given, and realized the error. Staff #2 notified the nurse, who instructed Staff #2 to hold Tenant #2's scheduled medications. Staff #2 checked on Tenant #2 at 10:00 p.m. and documented Tenant #2 had no complaints and Staff #2 noted nothing unusual about Tenant #2.

In an interview with Tenant #2, Tenant #2 stated he/she began to feel nauseated with the room spinning about midnight on the night medications were given in error. When Tenant #2 got up the following morning, 2-13-14, Tenant #2 reported not feeling well to staff. Tenant #2 reported feeling nauseated with the room spinning. Tenant #2 was taken to the hospital and kept for observation.

Tenant #2, an 88 year-old, was admitted on 5-15-09 and had diagnoses of: Diabetes Type II, Congestive Heart Failure, Hypertension, Chronic Renal Failure, and History of Right-Sided Stroke. Tenant #2 scored 29 of 30 on a Mini Mental State Examination (MMSE) dated 2-15-14 which indicated normal cognitive functioning.

The hospital documentation indicated Tenant #2 did well in observation and the symptoms resolved. Tenant #2 returned to the program. The program completed functional, cognition, and health evaluations upon return.

According to documentation on the medication error report, Staff #2 was taken off medication administration until re-delegation had occurred. In an interview with the Registered Nurse (RN), she stated Staff #2 had received further training on medication administration. Staff #2 was no longer administering medications to Tenant #2.

In an interview with the Director, she stated there is always another staff member available to administer medications when Staff #2 is working.

Training records were reviewed. Staff #2 received training from the RN on medication administration on 3-4-14.

Tenant #2 reported this was not the first time Staff #2 had given Tenant #2 medications that were prescribed for another tenant. The monitor asked for medication error reports going back to October 2013. None of the reports documented Staff #2 administering incorrect medications to Tenant #2.

In an interview, the RN stated Staff #2 may have caught the error before actually administering the medications. Tenant #2 reported Staff #2 has not administered medications to Tenant #2 since the incident.

Tenant #2 was given medications intended for another tenant. Staff #2 recognized the error immediately and contacted the RN. Staff #2 observed Tenant #2 during the evening shift. The next morning, staff responded to Tenant #2's report of not feeling well, and was sent to the hospital. Tenant #2 was observed in the hospital and returned with symptoms resolved. The program took Staff #2 off the schedule for medication administration, and provided re-training on medication administration. Per Tenant #2's request, the program provided staff other than Staff #2 to administer medications.

- Regulatory Insufficiency: None noted.

During the course of the investigation, the following was noted:

- Monitoring Observation: Incident reports were reviewed for the period of October 2013 to the time of the monitoring visit. A medication error report dated 11-11-13, documented an incident of 11-8-13, a Friday at approximately 8:00 p.m. The report documented Staff #2, a Certified Medication Aide (CMA), gave a suppository to Tenant #3 without a physician's order. The report documented Tenant #3 was in pain, Staff #2 felt sorry for Tenant #3, and did not trust that anything would be done on the weekend. The report documented Staff #2 was counseled on the scope of practice for a CMA.

  Tenant #3, a 92-year-old, was admitted on 10-27-12 and had diagnoses of: Diabetes Type II, Hypertension, History of Ischemic Stroke with Expressive Aphasia, Congestive Heart Failure, Hemiplegia, and Mental Status Changes. On 10-29-13 Tenant #3 was staged at three on the Global Deterioration Scale (GDS) which indicated mild cognitive decline.

  On 10-20-13, progress notes documented Tenant #3 was leaning to the right and was unable to move the right leg. Tenant #3's face was drooping and Tenant #3 was drooling. The ambulance was called and Tenant #3 was taken to the hospital. Tenant #3 returned from the hospital on 10-22-13. The progress notes documented physician orders were current. There was no documentation of pain or complaints of problems with the bowels in the progress notes.

  Functional, cognition, and health evaluations were completed by the RN on 10-22-13. The health evaluation documented Tenant #3 was occasionally incontinent of stool, had occasional loose stools, and occasionally exhibited bowel impaction. The evaluation form was a series of check boxes. A notation on the form dated 12-28-12 documented Tenant #3 used an anti-diarrheal daily for loose stools, had occasional constipation and had a history of issues with the bowels. Documentation on the health evaluation dated 10-22-12 stated Tenant #3 had a history of stroke and had difficulty finding and speaking words. There was no documentation of a more recent date to indicate the condition had resolved. The health evaluation did not document any pain was experienced by Tenant #3.

  The functional evaluation of 10-22-13 indicated the program administered medications to Tenant #3, documented Tenant #3 had a history of loose stools and constipation, and medications were taken per orders on the Medication Administration Record (MAR).

  Progress notes dated 10-29-13 documented changes to medication and dietary orders. Evaluations were completed. The health evaluation completed by the RN documented Tenant #3 was occasionally incontinent of stool, and had occasional loose stools. The evaluation no longer indicated Tenant #3 exhibited bowel impaction. The health evaluation indicated Tenant #3 had expressive aphasia and it was difficult to evaluate Tenant #3's cognitive status as occasionally Tenant #3 gave an inappropriate response. The health evaluation did not document any pain was experienced by Tenant #3.

  The functional evaluation of 10-29-13 documented no change from the 10-22-13 evaluation. The information from the functional evaluation was carried forward to the

service plan of 10-29-13. A review of the progress notes dated 10-29-13 through 11-18-13 documented no episodes of loose stools, constipation, impaction, or pain for Tenant #3.

A review of the November 2013 MAR revealed Tenant #3 was prescribed an antidiarrheal medication to be given daily in the morning. The medication was given daily November 1 through November 8, 2013. Tenant #3 also had an order for the medication to be given on an as needed basis, but no "as needed" doses were given November 1 through November 8, 2013. Tenant #3 had no orders on the MAR to treat constipation. A review of the November 2013 indicated Tenant #3 was prescribed nitroglycerin for chest pain, but there was no documentation Tenant #3 had any medication prescribed for general pain.

A medication error report dated 11-11-13 documented an incident of 11-8-13, when Staff #2 administered a suppository to Tenant #3 after Tenant #3 expressed pain. A review of the clinical record showed there was no documentation to indicate the type of pain Tenant #3 was experiencing. There was no documentation as to how Tenant #3, with expressive aphasia, made needs known. There was no documentation to indicate the suppository was prescribed by a physician. The medication error report documented Staff #2 "....did not trust that anything would be done on weekend." It also documented that the precautions to be taken to prevent this med error from occurring again would be for Staff #2 to, "trust nurses". The medication error report, signed by RN #2, documented there was no injury to Tenant #3, and the physician was not notified of the medication error. The clinical record lacked documentation of any follow-up evaluation by a nurse to determine Tenant #3's condition following administration of a medication for pain, a medication which is used to treat constipation, that was not ordered by the physician. There was no documentation in the clinical record the medication was administered.

An interview was conducted with Staff #2. Staff #2 reported one of the rights of medication administration was to make sure the medication was administered to the right tenant. After giving a medication, it was to be documented as given.

Staff #2 stated Tenant #3 was distressed about constipation on that Friday night. Tenant #3 kept asking to go to the bathroom and kept saying "bowel, bowel, bowel." Staff #2 reported she did not recall that Tenant #3 had been constipated prior to this episode, nor had Tenant #3 had any pain prior to this. Staff #2 reported Tenant #3 pointed to the stomach and indicated pain. The medication error report documented Staff #2 "felt sorry" for Tenant #3.

Staff #2 reported she took a suppository, (that belonged to a tenant who was deceased), later identified as a generic form of Bisacodyl, from the refrigerator. Staff #2 administered the suppository, but did not document it because the suppository was not ordered for Tenant #3. Staff #2 did not follow the procedure for medication administration which included documentation of the administration of medication immediately afterwards.

Staff #2 reported RN #2 was on-call, but she did not notify RN #2 of the situation. Staff #2 reported she sent an email to the RN so the RN could contact the physician for a suppository, but did not contact the RN to notify her of the situation. Staff #2

reported she did not notify a nurse of her concerns before administering the suppository and did not notify a nurse after the suppository was administered. Staff #2 reported another staff member reported the incident to a nurse.

Staff #2 stated she needed to learn to trust the nurses.

Staff #3 was interviewed. Staff #3 reported she does not pass medications. Staff #3 reported in November, Tenant #3 had the call light on. Staff #3 helped Tenant #3 to the bathroom. Tenant #3 was not complaining of pain on the way to the bathroom. Tenant #3 sat on the toilet and was moaning and in pain. Staff #3 does not recall that Tenant #3 said anything, but was moaning and had facial grimaces. Staff #3 reported Tenant #3 did not usually ask for something to help with a bowel movement. Tenant #3 grabbed the rail on the wall and moved side to side. Staff #3 sat with Tenant #3 for a couple minutes and Tenant #3 was unable to have a bowel movement. Staff #3 called Staff #2, to see if there was anything she could give to Tenant #3. Tenant #3 continued to sway and moan until Staff #2 returned about five minutes later. Staff #3 reported Staff #2 did not say anything except to ask Tenant #3 to stand and a desire for the suppository to work. Tenant #3 was escorted to bed. Staff #3 does not recall going back into Tenant #3's apartment to check on Tenant #3.

Staff #3 reported if something unusual were to occur on a shift, the occurrence was to be reported to the medication aide, and the medication aide would call the nurse. Staff #3 reported the nurses could be trusted, and the nurses took care of concerns right away.

The spouse of Tenant #3 was interviewed. The spouse reported Tenant #3 was on a medication for diarrhea and was sometimes constipated, but not too often. The spouse did not recall a time the constipation was painful. The spouse reported Tenant #3 says "yes" when meaning "no" and would agree to anything.

The RN was interviewed. She reported Tenant #3 had the anti-diarrheal medication ordered because Tenant #3 would eat breakfast and could not make it back to the apartment before a bowel movement would occur. The RN did not recall Tenant #3 had issues with constipation prior to the middle of November when the anti-diarrheal medication was held. The RN reported Tenant #3 would need an assessment to determine the pain and the reason for it to determine if a suppository would have been appropriate. The RN reported there were other non-pharmacologic interventions, such as warm water, that could be done without a physician's order. A physician's order would have been required to administer a medication, and would not be within the scope of practice of either a CMA or an RN to administer medications without an order.

The RN reported Tenant #3 does not always communicate accurately. Tenant #3 says "yes" but shakes the head "no" due to the expressive aphasia.

The RN reported when she asked Staff #2 to guarantee this would not happen again, Staff #2 did not give a clear answer.

RN #2 was interviewed and stated she learned of the incident of 11-8-13 from another staff member, but did not recall who. RN #2 reported Tenant #3 would have

breakfast and could not make it back to the apartment before a bowel movement would occur. RN #2 stated she looked at Tenant #3 the following day, checked Tenant #3's bowel sounds and had no concerns, but did not document her observations. RN #2 reported she was not aware that trust had been an issue for Staff #2 and did not recall that information on the form when she talked to Staff #2 after the incident.

RN #2 reported it was not within the scope of practice of the CMA or RN to administer medications without an order. RN #2 stated a tenant with pain would need to be assessed to determine the cause of the pain prior to giving a suppository. RN #2 reported Tenant #3 has a lot of systemic issues including the history of stroke, and has lots of doctors. The team would make the decision as to Tenant #3's care. RN #2 reported it would not be appropriate to take medications from one tenant to give to another. RN #2 reported Staff #2 knows when to notify the nurse.

Tenant #3 was reported to experience pain and constipation, which was not previously seen until Friday evening 11-8-13. Tenant #3 had expressive aphasia and had a known difficulty with communication. Tenant #3 was moaning. Staff #2 did not trust the nurses to do something over the weekend. Staff #2 did not notify a nurse directly to let the nurse know of immediate concerns. It was beyond the scope of practice for a CMA to assess Tenant #3 to determine the reason for the pain. Staff #2 took a medication prescribed for another tenant and administered the medication to Tenant #3 with no physician order for Tenant #3 to be given the medication. Staff #2 did not document the medication as given and did not report the incident after the fact to the nurses. The clinical record lacked documentation of an evaluation by a program nurse after the incident. A physician was not notified of the incident. Tenant #3 was not given the benefit of the care of a licensed healthcare professional with a change of condition.

- Regulatory Insufficiency: All tenants have the following rights: To receive care, treatment and services which are adequate and appropriate. (IAC r. 481-67.3(2))

B. Policies and Procedures

During the course of the investigation, the following was noted:

- Monitoring Observation: A medication pass was observed during the onsite visit. Staff #1 was observed passing medications to 10 tenants. Gloves were applied to assist with insulin administration or blood sugar checks. Hands were not washed between tenant contacts or with the removal of gloves on four occasions.

  The procedure for handwashing was not followed.

  On 11-8-13, Staff #2 administered a suppository on an "as needed" basis to Tenant #3. The suppository came from a deceased tenant and there was no physician's order for Tenant #3 to receive the medication. The program's guidelines on the use of "as needed" medications indicated the staff member was to look over the MAR and to give the "as needed" medication according to the parameters written out by the nurse,

and to give the medication the way the physician ordered it. The staff member was to always call a nurse if in doubt or had questions.
The guidelines on the use of "as needed" medications was not followed.

On 2-12-14, Staff #2 administered Tenant #1's medications to Tenant #2. The six rights of medication administration, including the right tenant, were not followed as indicated in the medication administration delegation procedure.

- 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)

C. Staffing

During the course of the investigation the following was noted:

- Monitoring Observation: A medication pass was observed on 3-19-14. During the medication pass Staff #1 stated Tenant #4 received nectar-thickened liquids. Staff #1 stated Tenant #4 drank chocolate milk with the evening meal, and the chocolate milk was thick enough and did not require an additive to make it the consistency of nectar.

  A review of the clinical record confirmed Tenant #4 had a physician's order for nectar thick liquids. Physician's orders also indicated Tenant #4 was to receive a can of liquid nutritional supplement.

  An interview with the Dietary Manager revealed he learned in school that chocolate milk did not need thickening for a nectar-thick diet. The Dietary Manager was asked what tool the staff used to determine whether or not a liquid needed to be thickened. The Dietary Manager provided a document labeled Diet Manual 2011 and titled Thickened Liquids, which was in the kitchen and posted for easy access. The document indicated milk and nutritional supplements were thin liquids, not nectar-thick.

  Staff #6 and #7, CMA's, were interviewed. Both stated they were not aware that chocolate milk or liquid nutritional supplements required thickening for Tenant #4.

  The program was asked to contact the Dietitian. The Dietitian reported to the monitor the need to thicken chocolate milk and the liquid nutritional supplement to meet the nectar-thickened requirement.

  Staff members did not demonstrate an understanding of nectar-thickened liquids.

  Staff #2 reported on 11-8-13, Tenant #3 was in pain and was constipated. Staff #2 reported she had not seen Tenant #3 with those conditions before. A medication error report confirmed the event. Staff #2 reported she sent an email to the nurse to request a suppository for Tenant #3. The clinical record lacked documentation of the event. The program was unable to provide staff documentation of an occurrence that

differed from Tenant #3's normal status. The progress notes did not contain an accounting of the incident.

Progress notes were reviewed for Tenant #2. A medication error report dated 2-12-14 documented Tenant #2 received another tenant's medication in error. Tenant #3 experienced nausea on 2-13-14 and was sent to the hospital for observation. On 2-14-14 Tenant #2 was discharged from the hospital and returned to the program. There was no documentation from any staff member that Tenant #2 had a change in health and was sent to the hospital. The progress notes did not contain an accounting of the incident.

Staff #5 was interviewed and stated she talked to the nurse face-to-face with concerns. Staff #5 stated there was no system for communicating with the nurse.

The Director was asked to provide documentation of staff communication to the nurse in reference to regulation IAC r. 481-67.9 (4)(g). The Director stated there was a communication book, but the documentation was not kept for three years.

The RN stated staff communicated with notes but did the RN did not always keep the notes. The RN asked the monitor for a copy of the regulation.

At exit, the Director stated staff was to communicate in writing in the progress notes.

The program did not have a system for written communication from the staff to the nurse documenting occurrences that differ from the tenant's normal health, functional or cognitive status.

- 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))

- Regulatory Insufficiency: The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request. (IAC r. 481-67.9(4)(g))

D. Service Plans

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #3 had a history of stroke with expressive aphasia. The current service plan dated 1-21-14 documented the existence of the aphasia but did not identify interventions to aid staff when communicating with Tenant #3. The service plan did not meet the identified needs of Tenant #3.

Tenant #5, a 90 year-old, was admitted on 10-9-10 and had diagnoses of: Diabetes, Hypertension, Gastroesophageal Reflux Disease, and Mild Dementia. Tenant #5 was staged at three on the GDS which indicated mild cognitive decline. The health evaluation with an entry dated 1-24-14 documented Tenant #5 stated "wants to die."

Staff #1 was interviewed and stated Tenant #5 has talked about wanting to die and does not know why he/she is still living. Tenant #5 said it was not worth it.

The RN was interviewed and stated Tenant #5 had talked about not eating and not taking medications as prescribed.

A review of the service plan dated 1-23-14, which corresponded with the assessment date at the top of the health form, and the service plan dated 3-4-14 did not identify Tenant #5 had suicidal thoughts and did not include interventions for suicidal thoughts.

The service plan was not based on the evaluation completed 1-23-14 which identified the suicidal thoughts and did not meet the identified needs of Tenant #5.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26(1))