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April 7, 2014

**Complaint/Incident Intake #: 47202-I**

Ms. Jill Colling, Director
Bickford Cottage II AL Memory Care
4022 Indian Hills
Sioux City, IA 51108

**RE: Final Recertification Monitoring Evaluation & Incident Investigation Report – Bickford Cottage II AL Memory Care, Sioux City, IA**

Dear Ms. Colling:

Enclosed is the **Final Recertification Monitoring Evaluation & 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 a survey by DIA on **March 11 and 12, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Dementia Specific Education, Mandatory Dependent Adult Abuse Training and Policies and Procedures.

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/emailed to DIA to my attention 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.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Also enclosed you will find the Assisted Living Program Certificate **S0063** with effective dates of **February 4, 2014** through **February 3, 2016.**

If you have any questions in regard to this 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 Recertification Monitoring Evaluation and Incident Investigation Report

**Assisted Living Program:** **Incident # 47202-I**

Bickford II Assisted Living Memory Care
Jill Colling, Director
4022 Indian Hills
Sioux City, IA 51108

**Date of Monitoring Visit:**

March 11 and 12, 2014 onsite
March 13, 14, and 17, 2014, off site

**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 were provided by the Program at the time of the on-site.

| Dementia-Specific Program by Dedication | |
|---|---|
| Number of tenants without cognitive disorder: | 0 |
| Number of tenants with cognitive disorder: | 26 |
| Total Population of Program at time of on-site | 26 |
| **TOTAL census of Assisted Living Program** | 26 |

**Tenant/Family Satisfaction Results** – Individual and group interviews were not completed as tenants were cognitively impaired. The building was toured. The building and grounds were generally neat and clean with no odors. The furniture was observed to be clean and stain-free. The kitchen was clean and organized. Door alarms were on all exit doors and observed to be functioning. Staff members were observed giving tenants choices, and treated the tenants kindly.

**Program History** – During the course of the Recertification visit conducted on March 11, 12, 13, 14 and 17, 2014, the program received regulatory insufficiencies in the areas of: Dementia Education, Mandatory Reporter Training for Dependent Adult Abuse, and Policies and Procedures.

**On-Site Monitoring Evaluation** – The monitor(s) made observations detailed in the following areas.

**A. Tenant Rights**

The program reported to the department Staff #1 was attempting to lead Tenant #1 out of the dining room so Tenant #1 would not slip on applesauce that had spilled onto the floor. Tenant #1 struck Staff #1; Staff #1 grabbed Tenant #1's arm, spun Tenant #1 around and proceeded to bear-hug from behind. (47202-I).

Monitoring Observation: Tenant #1, a 76 year-old, was admitted on 10-4-13 and had diagnoses of: Dementia and History of Left Hip Fracture with Surgery in September of 2013. Tenant #1 was staged at six on the Global Deterioration Scale which indicated severe cognitive decline. According to the service plan dated 1-29-14, Tenant #1 was independent with ambulation and transfers and was a fall risk.

An incident reported dated 2-5-14, timed at approximately 6:00 p.m., and completed by Staff #2 documented the incident as above. The incident report documented a staff member intervened and removed Tenant #1 from the situation. Staff #1 reported the incident to the Director.

The Director was notified by phone and came to the program immediately. The Director interviewed Staff #2. Staff #2 reported Staff #1 was cleaning the floor because applesauce had spilled. Staff #1 kept telling Tenant #1 to move because Staff #1 did not want Tenant #1 to fall. Initially the Director understood Staff #2 to report Staff #1 pulled Tenant #1's arms behind Tenant #1. When Staff #2 was interviewed by the Director, Staff #2 indicated Tenant #1's arms were down to the side, and Staff #1 had her arms in a bear-hug around Tenant #1 as Staff #1 was standing behind Tenant #1.

The Director interviewed Staff #1 who reported she did not want Tenant #1 to fall because of applesauce on the floor, which Staff #1 was trying to clean up. Staff #1 reported Staff #3 provided assistance. The Director suspended Staff #1 pending an internal investigation. Staff #1 was asked by the Director to demonstrate how Tenant #1 was bear-hugged. The demonstration indicated Tenant #1's arms were down at the sides, with Staff #1 behind with arms around Tenant #1. The Director did not think Staff #1 meant any harm to Tenant #1.

The Director reported Staff #1 was loud, and the program had identified interventions for Staff #1 in an effort to get Staff #1 to tone down the loud voice. The interventions and meeting with Staff #1 were put in place on the same day as the incident. The Director reported Staff #1 did not know how loud she was. The loud tone did not fit in with the environment the program wanted for its tenants with dementia. There had been no problems with Staff #1 in regards to tenant interaction other than the loud approach.

The Director reported Tenant #1 was not predictable. Tenant #1 would stay with a staff member when Tenant #1 keyed in on that staff member. Tenant #1 was described as busy, and liked to help.

The Director described the flooring in the kitchen as a laminate which would have been a slip hazard with applesauce on it.

The Registered Nurse (RN) was interviewed. The RN was notified of the incident by the Director. It was reported to the RN that Tenant #1 hit Staff #1, Staff #1 thought Tenant #1 was going to fall, and Staff #1 grabbed Tenant #1's hand, spun Tenant #1 around and hugged Tenant #1 from behind. Initially, the RN had an understanding that Tenant #1's hands were pulled behind Tenant #1, which was later found not to be true. Tenant #1 was bear-hugged from behind. Tenant #1's arms were not pulled behind as originally thought. The RN was not at the program at the time of the incident.

The RN observed Tenant #1 on 2-6-14, the following day. Tenant #1 was up and about as usual, transferred independently, and had no marks on the arms. Tenant #1 was able to move wrists, arms, and legs. The RN reported Tenant #1 was not capable of remembering the incident.

The RN reported Tenant #1 has struck at staff before this incident. Staff members have been trained to back away if Tenant #1 struck out. The RN reported Tenant #1 was steady on feet, walked slowly, did not use assistive devices, and has a history of falls.

The RN stated there were concerns over Staff #1's loud voice. The RN stated the dining room was a place for a calm atmosphere. The RN reported Staff #1's voice made tenants anxious. The program was working with Staff #1 for improvement.

The RN had general concerns about Staff #1; there had been no specific incidents with any tenant prior to this one.

The RN reported believed Staff #1 meant no harm and had good intentions.

Staff #2 was interviewed and stated after supper on 2-5-14, staff members were taking tenants out of the dining room so that the dining room could be cleaned. Staff #1 was assigned the dining room during that shift and was to complete the kitchen and dining room tasks. Staff #2 reported there was a mess on the floor with applesauce and Tenant #1 was stepping in it. Staff #1 was trying to get Tenant #1 out of the dining room. Staff #2 reported Staff #1 was loud and Tenant #1 was not leaving.

Staff #2 was escorting a tenant from the dining room, with Staff #2's back to the dining room. Staff #2 turned around when she heard the noise. Staff #2 saw Tenant #1 push Staff #1 on the shoulder. Staff #1 then grabbed Tenant #1 and spun Tenant #1 around. Tenant #1's arms were down at the side. Staff #1 was behind Tenant #1 and had Tenant #1 in a bear hug. Staff #2 told Staff #1 not to restrain Tenant #1. Staff #2 reported Tenant #1 was not picked up off the floor and was not moved.

Staff #3 then came to the dining room and asked what was happening. Staff #1 reported to Staff #3 that Tenant #1 was going to slip on the applesauce. Staff #1 let go of Tenant #1 and Staff #3 took Tenant #1 away from the situation.

Staff #2 told Staff #4 of the incident. Staff #4 told Staff #2 to report it. Staff #2 notified the Director.

Staff #2 reported Staff #1 was loud, acted without thinking, but meant no harm. Staff #2 reported she never saw Staff #1 hug or restrain anyone before. Staff #2 also reported the dining room floor was slippery when wet and the dining area was blocked for regular floor cleaning.

Staff #3 was interviewed and stated she was in the TV room when she heard a commotion. Staff #3 moved from the TV room to stand in the hallway and face the dining room. Staff #3 heard Staff #1 tell Tenant #1 "don't hit me." Staff #1 was not getting any help from Staff #2 after asking for help, so Staff #3 walked up and took Tenant #1 by the hand and led Tenant #1 away from the dining room. Tenant #1's hands were down by the side. Staff #3 observed Tenant #2 did not have red marks or bruises on the harms and Staff #1's grip was loose enough that Tenant #1 moved easily to Staff #3's hand.

Staff #3 reported Staff #1 was concerned Tenant #1 might fall in the applesauce. Staff #3 reported Tenant #1 might have fallen because the sock on Tenant #1's right foot was saturated with applesauce and the applesauce is slippery.

Staff #3 reported Staff #1 was loud and Staff #3 thought Staff #1 was hard of hearing. Staff #3 stated she told Staff #1 the loud voice made tenants "jumpy." Staff #3 stated Staff #1 was holding Tenant #1's hands to keep Tenant #1 from hitting and to keep Tenant #1 safe from falling in the applesauce. Staff #3 reported Staff #1 had no intent to harm. Staff #3 reported the floor was slick with the applesauce on it.

In a written statement to the program, Staff #1 reported Tenant #1 came into the dining room as Staff #1 was trying to clean up soup and applesauce that spilled on the floor Tenant #1 went to hit Staff #1 and Staff #1 put an arm up to protect her own face. Staff #1 saw Tenant #1 was standing in the applesauce and was afraid Tenant #1 was going to fall. Staff #1 turned Tenant #1 and put Tenant #1's hands by Tenant #1's side. Staff #1 put her hands over Tenant #1's so Tenant #1 wouldn't fall.

Staff #1 reported she received no assistance from Staff #2, who told Staff #1 not to hold Tenant #1 "like that." Staff #1 reported she was afraid Tenant #1 would fall. Staff #3 came to escort Tenant #1 away from the dining room.

A review of Staff #1's training records documented received eight hours of dementia training on 12-16-13 and mandatory reporter training for dependent adult abuse on 2-6-14.

On 2-5-14, Staff #1 was in the dining room cleaning after supper was completed. Tenant #1 was in the dining room. Staff #1 was afraid Tenant #1 would slip and fall in the applesauce that was on the floor. Tenant #1 struck at Staff #1. Staff #1 put a hand out, turned Tenant #1, and kept Tenant #1's arms at the side in an effort to prevent Tenant #1 from falling. Tenant #1 was escorted from the dining room by Staff #3. Tenant #1 did not fall and sustained no injuries as a result of having the arms held by the side of the body.

Tenant #1 was cognitively impaired and had no recollection of the incident. Tenant #1 was independent with ambulation, but had a history of a fall resulting in a hip fracture and was identified on the service plan as a fall risk.

The dining room floor was a laminate which was described as slippery when wet or with applesauce.

Staff #1 was described as loud, but had no other incidents involving inappropriate behavior with any tenant. The program had put interventions in place to work with Staff #1 in regards to a loud tone and the care of persons with dementia. Staff #1 had received required training shortly after employment began.

The program appropriately reported the incident to the department in a timely manner.

Regulatory Insufficiency: None noted.

**B. Dementia-Specific Education for Program Personnel**

Monitoring Observation: The program is dementia-specific by dedication. Training records were reviewed for Staff #5 and #6. Staff #5 was hired 7-2-13 as a Certified Nursing Assistant (CNA). Staff #6 was hired 8-23-13 as a Certified Medication Aide (CMA). Training files lacked documentation of the completion of any dementia training.

Regulatory Insufficiency: All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. (IAC r. 481-69.30(1))

## C. Mandatory Reporter Training for Dependent Adult Abuse

Monitoring Observation: Training records were reviewed for Staff #5 and #7. Staff #5 was hired 7-2-13 as a CNA. Staff #7 was hired 1-3-13 as a CNA. Staff #5 had no documentation of any training on dependent adult abuse. Staff #7 completed training on 9-10-13, eight months after hire. Mandatory reporter training was not completed within six months of hire.

Regulatory Insufficiency: A person required to report cases of dependent adult abuse pursuant to section 235B.3, other than a physician whose professional practice does not regularly involve providing primary health care to adults, shall complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment or self-employment which involves the examination, attending, counseling, or treatment of adults on a regular basis. Within one month of initial employment or self-employment, the person shall obtain a statement of the abuse reporting requirements from the person's employer or, if self-employed, from the department. The person shall complete at least two hours of additional dependent adult abuse identification and reporting training every five years. ((235B.16(5)(b))

## D. Policies and Procedures

Monitoring Observation: Staff #8 was observed passing medication on 3-12-14 shortly after 5:00 p.m. Staff #8 was observed washing hands prior to the medication pass. Staff #8 then passed medications to four tenants. Three of the tenants had medications crushed. Staff #8 was not observed washing or sanitizing hands between tenant contact. Staff #8 stated she washed hands after every two to three tenant contacts when passing medications.

According to the procedure outlined in staff training, hand washing was to be completed between contact with different tenants, and providing direct care or hands-on task.

The procedure for handwashing was not followed.

Staff #3 was observed in the dining room during the evening meal on 3-12-14. A tenant was observed not eating. The tenant had half a sandwich on the plate. Staff #3 used bare hands to bring the sandwich up to the tenant's face in an effort to get the tenant to eat.

According to the procedure for the use of gloves, gloves were to be worn when handling food directly when there is no opportunity for the food to be cooked.

The procedure for the use of gloves was not followed.

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)