IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

April 14, 2008

Complaint Intake: #12590R2
#12594R2
#13835R
#15431

Christina Bricker, Divisional Director of Operations
Bickford Cottage Assisted Living
3500 Lower West Branch Road
Iowa City, IA 52245-4106

RE: I. Final Complaint Investigation & Revisit Report – #12590R2, #12594R2, #13835R and #15431
II. Immediate Sanction – Conditional Operation
III. Civil Penalty
IV. Hearings and Appeals
V. Conclusion

Dear Ms. Bricker:

I. Final Complaint Investigation & Revisit Report – Bickford Cottage, Iowa City, IA

Enclosed is the **Final Complaint Investigation & Revisit Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2007) and Iowa Administrative Code, chapters 321—25, pertaining to assisted living programs and 321—26, pertaining to monitoring, civil penalties and complaints regarding assisted living programs. **The Final Report notes the Regulatory Insufficiencies as defined in the areas of:** Occupancy Agreement, Evaluation of Tenant, Service Plan, Medications, Nurse Review, Staffing, Life Safety, Exit Door Alarm System and Other.

DIA is accepting the Plan of Correction (POC) following the program's submission of additional information.

II. Immediate Sanction - Conditional Operation

As reflected in this Report, the program failed to comprehensively follow the regulations in 321 IAC Chapter 25. Due to the program's noncompliance, current Regulatory Insufficiencies and

the findings from the on-site monitoring visit of January 8-11, 2008, Bickford Cottage's Conditional Certificate, effective October 31, 2007, is being extended. In addition, the program will not be allowed to admit new tenants until such time as the restrictions and/or conditional certificate is lifted by the department. The program will need to submit weekly reports to DIA in regard to catheterization of Tenant #10, medication reviews will need to be documented weekly and provided to DIA, Life Safety training for all staff will need to be completed and an outside entity will need to visit the program to assess all doors for code compliance and submit documentation to the State Fire Marshall's office and the DIA. The above sanctions are effective immediately based on the department's determination pursuant to 231C.11 that an imminent danger exists for the tenants.

While effective immediately, the program may appeal these sanctions by filing an appeal within 30 days of issuance of this letter.

III. Civil Penalty

If no appeal is requested within 30 days of receipt of this Final Complaint Investigation Report the civil penalty obligation, in the amount of ten thousand ($10,000.00) dollars, is required.

IV. Hearings/Appeals

The Program may appeal the DIA decision in accordance to 321 IAC 26.4, within 30 days of notice, by submitting a request for appeal to the DIA. Hearings will be held pursuant to 481 IAC Chapter 10. If the program appeals, the civil penalty will be suspended, pending appeal. If the program does not appeal, the fine is due within 30 days of notice.

V. Conclusion

The Plan of Correction submitted, is accepted. The Conditional Certificate and above sanctions remain. DIA may revisit the program to confirm compliance in fulfilling the POC's corrective measures. If the program wishes to appeal or request a hearing on the final findings, the program may do so within 30 days of this letter.

If you have any questions in regard to these matters, please contact me at (515) 281-5077.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Complaint Investigation Report & Revisit

Assisted Living Program:

Christina Bricker, Divisional Director of Operations
Bickford Cottage Assisted Living
3500 Lower West Branch Road
Iowa City, IA 52245-4106

Complaint Intake #: **#12590R2**
#12594R2
#13835R
#15431

Date of Investigation:

January 8, 9, 10 & 11, 2008

Monitor(s):

Stephanie Cummins, SW MA
Ann Martin, RN

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or 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 rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation and revisit were conducted at Bickford Cottage Assisted Living on January 8, 9, 10 & 11, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* –Not applicable.

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by or holds itself out as providing specialized care in a dedicated setting but may have tenants without cognitive disorder.

Current number of tenants in a DSP that serves 5 or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale (GDS):	11
Current number of tenants without cognitive disorder:	19
Total Population:	30

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Program History – There were substantiated complaints this certification period in the areas of: Occupancy Agreement, Evaluation of Tenants, Criteria for Exclusion of Tenants, Tenant Documents, Service Plans, Medications, Nurse Review, Staffing, Managed Risk, Activities Life Safety, Structural Requirements and Other.

The complaint history during this certification period includes the complaint investigation of July 17 & 18, 2007, which resulted in a fine of $3,000.00. The complaint and revisit of October 3, 4 & 5, 2007, resulted in a $6,000.00 fine and sanctions including a conditional certificate effective October 31, 2007, and a restriction on admissions.

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

A. Occupancy Agreement – The program shall enter into an occupancy agreement with the tenant or tenant's legal representative, if applicable, prior to the tenant's taking occupancy that clearly describes the rights and responsibilities of the tenant and of the program, and shall sign a managed risk policy disclosure statement. [321 IAC 25.22]

The program received a regulatory insufficiency in the October 2007 report related to the program not consistently obtaining signed occupancy agreements for all tenants prior to them taking occupancy. (25.22)

Monitoring Observation: Two tenants that were admitted since the last onsite were reviewed. One of the two tenants did not have an occupancy agreement signed prior to taking occupancy.

Tenant #14, an 82 year old, was admitted on 10-15-07 and diagnoses include: Dementia and Non-ischemic Cardiopathy. The tenant did not have a signed occupancy agreement at the time of the onsite.

- Regulatory Insufficiency: The program does not consistently obtain signed occupancy agreements for all tenants prior to taking occupancy. (25.22(1))

B. Evaluation of Tenant - The program evaluates each tenant's functional and cognitive abilities and health status and the determination of needed services as required. [321 IAC 25.23(1) and/or (2)]

The program received a regulatory insufficiency in regard to Tenants #4, #5, #6, #7 and #10 in the October 2007 report related to not consistently evaluating tenants' functional and cognitive abilities and health status, as needed, with a change in condition.

Monitoring Observation: Tenant #4 was discharged on 10-5-07 and Tenant #6 was discharged on 12-20-07.

On 12-24-07, Tenant #5 was ordered Levaquin 500 mg, by mouth, for five days for a possible Urinary Tract Infection (UTI). The tenant's current service plan addresses physical therapy (PT) and occupational therapy (OT); however, an order for PT/OT was not found. Evaluations were not completed as needed.

Tenant #7, a 96 year old, was admitted on 5-26-04 with a diagnosis of Neuropathy. The tenant scored a five on the Global Deterioration Scale on 1-9-08, which indicated moderately severe cognitive impairment. Evaluations were completed on 11-14-07, as indicated in the POC. There was an order for a supplement twice daily dated 12-18-07 due to a 12.5 pound weight loss over the last year. Evaluations were updated; however, they were updated on 1-3-08. Evaluations were not completed as needed.

Tenant #10, a 93 year old, was admitted on 11-11-02 and diagnoses include: Atrial Tachycardia, Dementia, Detrussor Decompensation, Gilbert Syndrome, Glaucoma and Hypertension (HTN). Evaluations were completed on 11-14-07, as indicated in the POC.

During the course of the investigation, the following information was obtained.

Tenant #8, a 93 year old, was admitted on 6-22-07 and diagnoses include: Dementia, Cerebrovascular Accidents (CVA) and Aortic Stenosis.. The tenant scored a five on the GDS, which indicated moderately severe cognitive impairment. On 1-3-08, the tenant was started on a Z-pack for five days, an Albuterol inhaler four times a day, as needed, and vital signs one time each shift for five days due to an Upper Respiratory Infection (URI). Evaluations were not completed when the new orders were stopped.

Tenant #13, an 87 year old, was admitted on 2-25-06 and diagnoses include: HTN, Dementia and Congestive Heart Failure (CHF). The tenant was staged a five on the GDS, which indicated moderately severe cognitive impairment. According to a discharge list and the tenant's service plan, the tenant's spouse died on 12-20-07. The tenant eloped on 12-29-07, according to an incident report. Evaluations were completed on 12-8-07 and 1-3-08. Evaluations were not completed as needed.

Tenant #14 did not have a cognitive evaluation completed within 30 days of taking occupancy. The functional evaluation was updated on 12-20-07 due to a change; however, the health and cognitive evaluations were not completed as needed. According to incident reports, the tenant was found on the ground or fell, 15 times from 12-3-07 through 12-27-07. Evaluations were completed on 12-20-07; however, they were not completed as needed.

- Regulatory Insufficiency: The program did not consistently complete cognitive, health and functional evaluations within 30 days and as needed (25.23(2))

C. Criteria for exclusion of tenants - Program does not admit or retain tenants that require a higher level of care, unless a written exception has been applied for and approved. [321 IAC 25.23(3); 25.24]

The program received a regulatory insufficiency in regard to Tenant #4 in the October, 2007 report related to not consistently excluding tenants who exceeded occupancy and transfer criteria.

Monitoring Observation: Tenant #4 was discharged on 10-5-07. Staff interviews and tenant file audits did not identify any tenants that exceeded the occupancy and transfer criteria.

- Regulatory Insufficiency: None noted.

D. Tenant Documents – Program maintains a complete file for each tenant containing all appropriate documentation. [321 IAC 25.27]

The program received a regulatory insufficiency in regard to Tenant #7 in the October, 2007 report related to not consistently maintaining a complete file for each tenant, including a copy of the documentation of a legal representative.

Monitoring Observation: Tenant #7's progress notes dated 1-3-08, indicated the tenant's family member was called regarding Durable Power of Attorney (DPOA) paperwork that needed to be activated. The family member was informed that there was a need for a DPOA for healthcare, not a living will. The progress notes indicated the tenant's family

would bring in DPOA activation papers and will work with an attorney to draft and execute the DPOA for healthcare paperwork. The tenant signed the most recent service plans dated 11-14-07, 1-3-08 and 1-9-08.

- Regulatory Insufficiency: None noted.

E. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. [321 IAC 25.28]

The program received a regulatory insufficiency in regard to Tenant's #4, #5, #6, #7 and #8 in the October, 2007 report related to not consistently developing service plans for tenants with a change in condition.

The program received a regulatory insufficiency in the October, 2007 report related to not consistently updating service plans that were conducted in accordance with (25.23(1)) and (25.23(2)) and designed to meet the specific service needs of the individual tenant.

The program received a regulatory insufficiency in the October, 2007 report related to not consistently developing service plans that meet the identified needs of the tenants.

The program received a regulatory insufficiency in the October, 2007 report related to not consistently developing service plans that identified planned and spontaneous activities for those unable to plan their own activities, including those with dementing illness.

The program received a regulatory insufficiency in the October, 2007 report related to not consistently developing service plans that were developed and signed by a health professional, two staff and the tenant or the tenant's legal representative.

Monitoring Observation: Tenant #4 was discharged on 10-5-07 and Tenant #6 was discharged on 12-20-07.

Tenant #5 was ordered Levaquin, 500 mg by mouth, for five days on 12-24-07 for a possible UTI. The tenant's current service plan addressed PT and OT; however, an order for PT and OT was not found. The service plan was not updated when the medication was finished and, therefore, continued to be reflected on the service plan. The service plan was not updated as needed and did not reflect the current and identified needs of the tenant.

Tenant #7 had a service plan completed on 11-14-07, as indicated in the POC. The service plans dated 11-14-07, 1-3-08 and 1-9-08, were signed appropriately. The tenant's service plan addressed planned and spontaneous activities for the tenant. There was an order for a supplement twice daily dated 12-18-07 due to a 12.5 pound weight loss over the last year. The service plan was updated; however, it was updated on 1-3-08. The tenant had orders to encourage leg elevation, daily ambulation with walker and gait belt, Mupirocin 2% ointment applied to affected area twice daily, and to wash scrotum and perineum area and dry carefully twice daily. These treatments were on the MAR; however, were not on the service plan. The tenant received Proshield Plus Skin Protectant as needed and the tenant's voiding was timed every two hours while awake, according to the MARs. These treatments were not on the service plan. The service

plan was not updated, as needed, and did not reflect the current and identified needs of the tenant.

Tenant #8 had a service plan completed on 11-14-07, as indicated in the POC. The tenant's service plan addressed planned and spontaneous activities for the tenant. The tenant was started on a Z-pack for five days, Albuterol inhaler, four times a day as needed and vital signs one time each shift for five days as ordered on 1-3-08 for a URI. The service plan was not updated to remove the medications that were no longer being utilized. The service plan was not updated as needed and did not reflect the current and identified needs of the tenant.

During the course of the investigation, the following information was obtained.

Tenant #10 had orders for a straight catheter, four times daily, with staff to document the output and notify the nurse if the tenant refuses. It was also ordered to push fluids. The tenant's service plan dated 12-21-07 did not address the tenant's refusal of catheter care and the notification of the nurse or the nursing order to push fluids. The service plan did not reflect the current and identified needs of the tenants.

Tenant #13's service plan addressed planned and spontaneous activities for the tenant. The tenant's spouse died on 12-20-07, according to a discharge list and summary. The tenant eloped on 12-29-07, according to an incident report. The service plan dated 1-3-08 indicated the tenant was wearing a Home Free watch and had recently developed some exit seeking behaviors. The service plan was updated on 1-3-08; however, was not updated as needed and did not reflect the current and identified needs of the tenant.

Tenant #14's service plan addressed planned and spontaneous activities for the tenant. According to incident reports, the tenant was found on the ground or fell, 15 times from 12-3-07 through 12-27-07. The service plan was updated once, as needed, on 12-21-07. The service plan did not address the tenant's Home Free watch and the tenant's use of the scooter. The service plan was not updated, as needed, and did not reflect the current and identified needs of the tenant.

- Regulatory Insufficiency: Regulatory Insufficiency: The program did not consistently update service plans for tenants, with a change in condition. (25.28(3))

- Regulatory Insufficiency: The program did not consistently develop service plans that meet the identified needs of the tenants. (25.28(4)a)

- Regulatory Insufficiency: The program did not consistently develop service plans in accordance with 25.23(1) and 25.23(2) and designed to meet the specific service needs of the individual tenant. (25.28(1))

F. Medications – Program has a comprehensive written medication policy that allows tenant self-administration, but accommodates the need for tenant medication assistance via nurse delegation. The medication assistance is appropriately supervised and administered. Medications are appropriately stored. [231C.16A]

The program received a regulatory insufficiency in the October, 2007 report related to not consistently following an acceptable medication protocol.

Monitoring Observation: According to the Director of Risk Management, it was reported that a staff left the medication tote in a tenant's apartment by the previous shift. Staff #12 admitted that she had "forgotten" to take the medication tote out of the tenant's apartment. The Director of Risk Management indicated she had been told Staff # 12 had also left the medication tote in a tenant's apartment one time prior to the incident mentioned. Staff # 12 denied that incident occurred. Staff # 12 is no longer employed at the program.

Tenant #7 had an order to encourage leg elevation as much as possible. The December Medication Administration Record (MAR) did not have any initials that indicated this was completed. The tenant had an order for Mupirocin 2% ointment to be applied to the affected area twice daily. The December MAR did not have any initials that indicated this was completed. The tenant had an order for staff to wash the tenant's scrotum and perineum area and dry carefully twice daily. The December MAR did not have any initials that indicated this was completed. There was an order for a supplement, twice daily, due to weight loss. The supplement was on the service plan dated 1-3-08; however, it was not on the December 2007 MAR. Tenant #7's order for foot soaks was discontinued on 10-18-07.

Tenant #8 had an order to encourage leg elevation. The December MAR did not have any initials that indicated this was completed.

Tenant #9 had an order for Zolpidem, 5 mg, one tablet by mouth at bedtime, as needed. The November 2007 MAR indicated the Zolpidem was initialed on 11-2-07 at 0250, however, the staff did not sign the back of the MAR. The medication was initialed twice on 11-3-07 at 2230 and 2245, according to the MAR. Neither dose was initialed on 11-3-07 or signed on the back of the MAR. Progress notes dated 11-3-07 at 2245 indicated staff gave, as needed, Zolpidem, 5 mg, from the medication lock box in the tenant's room, per the tenant's request. Staff #11 was notified the pill came from the tenant's room and not from the bubble pack. According to the November 2007 MAR, on 11-4-07 the medication was initialed twice at 2000 and 0240; however, only the dose at 2000 was signed on the back of the MAR. On 11-19-07 a dose was initialed on the front of the MAR; however, was not signed on the back of the MAR. According to the November 2007 MAR, on 11-21-07 two doses were initialed, one at 1910 and another at 2300. The 1910 dose was the only dose initialed on the back of the MAR. The December 2007 MAR had indicated on 12-5-07 at 0130 a medication dose was administered. Initials were also located under the 5th day of the month with a time of 0215. On the back of the MAR the 0130 dose was signed out on 12-5-07 and the 0215 dose the handwriting was too difficult to determine.

Tenant #10 had an order for a straight catheterization four times per day. The tenant also had an order to catheterize the tenant every two hours or as requested if there were more than 500 cc's of urine. According to the documentation on the December 2007 MAR the tenant was not consistently catheterized every two hours when there was more than 500 cc's of output. The order indicated if the tenant refused catheterization at the ordered intervals, staff was to notify the nurse. There was no documentation of nurse contact regarding tenant refusal, despite refusals noted on the MAR. The table below demonstrates the output recorded four times daily for the month of December 2007 and if the tenant was catheterized every two hours if there was more than a 500 cc output.

Month/day/year Tenant #10	CCs recorded at 0600	CCs recorded at 1300	CCs recorded at 1900	CCs recorded at 2300	PRN catheterization documented Time/output
12-1-07	375	375	400	375	None
12-2-07	650	400	550	Refused	0145 550 cc
12-3-07	300	700	375	800	0240 750 cc
12-4-07	325	300	Refused	Not recorded	0100 175 cc
12-5-07	600	600	200	400	0200 875; 750
12-6-07	Not recorded	350	300	500	None
12-7-07	400	500	500	400	None
12-8-07	600	350	400	300/500/800 too difficult to determine	None
12-9-07	450	400	450	550	0130 100cc
12-10-07	725	600	Refused	875	0820 475
12-11-07	400	350	Refused	360 or 350	1400; 300 cc 2100; 575
12-12-07	Too difficult to determine	375	475	500	Time-not able to determine 500 cc
12-13-07	525	400	425	refused	Time and cc not able to be determined
12-14-07	550 unable to determine	600	Refused	400	None
12-15-07	800 unable to determine	475	250	350/unable to determine	None
12-16-07	600	500	275	350	2400 500
12-17-07	Unable to determine	400	450	450	None
12-18-07	500	500	400	300	None
12-19-07	800	300	400	575	None
12-20-07	500	325	425	450	None
12-21-07	625	350	300	400	None
12-22-07	160	300	400	300	None
12-23-07	350	650	400	425	None
12-24-07	725	575	550	550	None
12-25-07	500	550	400	500	0330 500 cc
12-26-07	550	500	400	300	None
12-27-07	400	450	Not recorded	600	None
12-28-07	450	600	Refused	525	Time-unable to

					determine 275 cc
12-29-07	600	600	Refused	400	1630 675 cc
12-30-07	200	400	300	500	0230 200 cc
12-31-07	600	500	250	325	None

Tenant #10 had a daily order for blood pressures and an order dated 1-3-08, for staff to notify the nurse, who will notify the physician, if the tenant's systolic blood pressure was greater than 150 or the diastolic blood pressure was greater than 100. The tenant's blood pressure on 1-3-08 was 180/88. The tenant was catheterized at 0930, staff collected 400 cc's of urine and laid the tenant on the left side for 30 minutes. The tenant's 1000 blood pressure was 150/70. The tenant had received a.m. doses of Benazepril HCL, 40 mg, every day and Clonidine HCL, 0.3 mg, twice daily. The fax indicated for the month of December 2007 the a.m. blood pressures exceeded 150/100 the majority of the days. An order was received to increase Benazepril to 40 mg in the a.m. and 20 mg at bedtime. Another fax was sent to the tenant's physician on 1-9-08 and stated the tenant's blood pressure was taken at 0630 and it was 212/90. It was taken again at 0730 and it was 180/90. The tenant was administered the Benazepril 40 mg at 0730. A fax to the physician dated 1-10-08, provided the tenant's blood pressures from 1-3-08 to 1-10-08 and indicated the tenant's blood pressure was very high. An order was received to discontinue Benazepril 20 mg at hs and start Benzapril 40 mg twice daily. The table below demonstrates the systolic and diastolic readings daily and any documented communication to the nurse throughout the month of December 2007. The tenant's systolic and diastolic blood pressures were documented as exceeding 150/100 throughout the month of December 2007 without consistent documentation of nurse notification. Communication to the tenant's physician was not documented throughout December 2007 despite the majority of the days of the month the tenant was exceeding blood pressures of 150/100. Adverse blood pressures were not consistently called to the RN, as ordered, between 12-01-07 and 12-21-07.

Tenant #14 had an order for daily weights to be taken and for staff to notify the nurse if there was a three pound or more gain. The tenant also had an order for Lasix, 40 mg,, to take one half tablet by mouth every morning, as needed, for pedal edema. The table below demonstrates December 2007 daily weights recorded, weight fluctuations noted, documentation of notification of the nurse if there is more than a three pound weight gain and the doses of the, as needed, Lasix administered. The nurse was not consistently notified when there was more than a three pound weight gain and the, as needed, Lasix was not routinely given despite weight fluctuations. The Tenant's weights were not consistently reported to the RN, as ordered, between 12-01-07 and 12-21-07.

- Regulatory Insufficiency: The program did not consistently follow an acceptable medication/treatment protocol as required. (IAC 655-Chapter 6)

G. Nurse Review - Program provides a registered nurse to ensure the appropriate administration and documentation of medications, ensure that physician orders are current, and assess and document the tenants' health related activities. [321 IAC 25.30]

The program had received a regulatory insufficiency in regard to Tenant #4 and Tenant #5, related to not completing nurse review, as needed, with a change.

Monitoring Observation: Tenant #4 was discharged on 10-5-07.

Tenant #5 was ordered Levaquin, 500 mg, by mouth for five days on 12-24-07 for a possible UTI. The tenant's current service plan addresses PT and OT; however, an order for PT and OT was not found. Nurse review was not completed as needed.

During the course of the investigation, the following information was obtained.

Tenant #7 had an order for a supplement twice daily dated 12-18-07 due to a 12.5 pound weight loss over the last year. Nurse review was not completed, as needed.

Tenant #8 was started on a Z-pack for five days, an Albuterol inhaler four times a day, as needed, and staff were to check vital signs once each shift for five days as ordered on 1-3-08 for a URI. Nurse review was not completed when the new orders were stopped.

Tenant #13's spouse died on 12-20-07 according to a discharge list and the tenant's service plan. The tenant eloped on 12-29-07, according to an incident report. Nurse review was completed on 12-8-07 and 1-3-08. Nurse review was not completed, as needed.

Tenant #14 was found on the ground or fell approximately 15 times from 12-3-07 through 12-27-07. Nurse review was not completed, as needed, for a change in condition.

- Regulatory Insufficiency: The program did not consistently assess and document the health status of each tenant, make recommendations and referrals as appropriate, and monitor progress on previous recommendations at least every 90 days, or if there were changes in health status. (25.30(3))

H. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Complaint Allegation #13835: The program received a regulatory insufficiency related to not consistently providing sufficient trained staff at all times to fully meet the identified needs of the tenants.

Monitoring Observation: Staff #7 indicated she assisted tenants with medications, treatments and personal cares. Staff #7 stated the former nurse reviewed blood pressures, positioning, blood sugars, catheter care and medications when she started. She indicated the former nurse watched a medication pass, eye drops, blood sugars and oxygen; however, one of the CMAs showed her catheter care, followed by the former nurse going over, step by step, verbal instruction by telephone and later watching her do the care. Staff #8 indicated she assisted tenants with medications, treatments and personal cares and she had one on one delegation with the former nurse. Staff #8 indicated she read through procedures and she did hands on demonstration for the former nurse. In regard to Ted Hose, she described to the former nurse how she would put on Ted Hose. Staff #8 indicated she received verbal delegation from the former nurse related to medications and she went through each individual tenant and signed documents. In regard to catheter care, she watched two CMAs do the catheter care, then a CMA watched her and then the former nurse evaluated her. Staff #8 indicated the former nurse was the only nurse that

provided nurse delegation training. Staff #9 indicated she assisted tenants with Ted Hose and personal cares. She had verbal training from the former nurse and went through the steps regarding Ted Hose. Staff #9 stated that was her only training. Staff #7 and Staff #8 had nurse delegated documents for medications and treatment that were tenant specific. The documents indicated the nurse delegated training involved a practicum. Staff #9 had nurse delegated documents related to Ted Hose. The documents indicated the nurse delegation training involved practicum.

Staff #7 indicated there were two CMAs and a CNA that work on third shift. Staff #7 indicated tenants received medications on third shift and she was not aware of any tenants that have requested a medication on third shift that did not receive it. Staff #7 indicated Tenant #10 was getting the required catheter care or he/she will let staff know. Staff #5 indicated she was not aware of a tenant that requested medication at night when it was not administered. Staff #1 indicated the tenants were getting their needs met on third shift. Staff #3 indicated she was not aware of any tenants not getting medications at night and said staff had been delegated or they call someone in.

According to a program document, there were currently no tenants that received Hospice services. Tenant #4 was discharged on 10-5-07. Staff #3 indicated on first shift there were no task sheets and staff knew what to do. Staff #5 indicated there were no task sheets put into practice.

Staff #1, Staff #3, Staff #7, Staff #8 and Staff #9 indicated staffing was sufficient to meet the needs of the tenants.

- Regulatory Insufficiency: The program did not consistently provide sufficient trained staff available at all times to fully meet tenants' identified needs. (25.33(1))

Complaint Allegation #15431: It was alleged there was one staff on duty on either 12-14-07 or 12-21-07 on third shift.

Monitoring Observation: A community meeting with two tenants and two tenant interviews were held. The tenants indicated there were two staff on third shift. According to staff interviews the staffing pattern was three direct care staff on first and second shifts and two direct care staff on third shift. Staff #5 indicated when there was a big snowstorm, a staff had called in; however, the third shift staff was never alone. Staff #9 indicated when the last big snow storm occurred the other staff on third shift could not come in due to the weather. The former nurse was in the building the entire shift and another direct care staff, who could not leave due to the weather, was also available. The direct care staff was in the building the entire shift, according to Staff #9. Staff #9 indicated she did not have any problems meeting the needs of the tenants and there was not a delayed response to the tenants that night. The schedule indicated two staff were scheduled on third shift on both 12-14-07 and 12-21-07.

- Regulatory Insufficiency: None noted.

Complaint Allegation #15431: It was alleged staff discussed using marijuana and other illegal drugs. It was alleged this might have contributed to the incidents with elopement

(however, the complainant had no information to associate the alleged drug use with the elopements).

Monitoring Observation: A community meeting with two tenants and two tenant interviews were held at the time of the onsite. The tenants indicated they had not heard staff discussing inappropriate topics at work.

Staff #3 indicated she was not aware of staff that used marijuana or other illegal drugs and she had not heard staff talking about illegal drugs. Staff #7 indicated she was not aware of staff discussion of illegal drug use. She did indicate one staff smelled of alcohol, approximately one week ago and she smelled alcohol on the staff's person and not on her breath. Staff #7 indicated the staff did not act impaired. Staff #1 indicated she had not heard staff discuss illegal drugs. Staff #1 reported one staff came into work with stamps on her hands and alcohol could be smelled on the staff's breath. Staff #1 reported the staff had the jitters and the staff did not provide any direct care with the tenants. Staff #1 indicated a tenant complained of smelling alcohol and was worried about his/her spouse's care. The tenant was interviewed and reported no issues on third shift and indicated he/she had no concerns with anyone coming in to deliver care to his/her spouse.

According to a Supervisory Note dated 1-11-08, Staff #7 reported to the Divisional Director of Operations, that Staff #9 had shown up for work and Staff #7 thought she smelled alcohol around Staff #9. Staff #9 reported she had not consumed any alcohol that day or evening and the Divisional Director of Operations did not audibly observe any form of voice slur or hesitation or any other demeanor that gave concern of the staff being under the influence. Staff #9 was asked if she would immediately take a blood alcohol test and she indicated she would have no problem in doing so if instructed. Staff #9 indicated she thought Staff #7 might have smelled alcohol from her jacket due to the fact she wears it to the bars and maybe that was what Staff #7 smelled. Staff #7 indicated she was very sensitive to the smell of alcohol and smoke and it was Staff #9's coat she smelled. No further incidents have been reported as of the day of the writing, according to the Divisional Director of Operations.

- Regulatory Insufficiency: None noted.

Complaint Allegation #15431: It was alleged Tenant #13 eloped and was found, laying in the snow. It was alleged later that night, Tenant #8 eloped and the doors alarms sounded for each incident; however, staff ignored the alarms. It was alleged Tenant #16 had to find staff and notify the staff the alarm was going off. It was alleged staff did not seem to know how to shut off alarms when they sounded.

Monitoring Observation: Staff interviews, progress notes and incident reports indicated Tenant #8 had not eloped on the same day Tenant #13 eloped. According to documentation from the Home Free Report on 12-31-07 at 8:22:39 p.m. the front door alarmed was reset at 8:22:42 p.m. On 1-1-08 at 10:52:44 p.m. the front door alarmed and was reset at 10:52:57 p.m. On 1-1-08 at 7:43:12 a.m. the #110 door alarmed and was reset at 7:43:59. Staff #1 indicated, Tenant #8 had never physically gotten out of the building and the tenant will set off the alarm and go back to his/her apartment. The tenant had a managed risk for exit seeking behavior.

According to an incident report dated 12-29-07, Tenant #13 eloped out the Northeast exit door. Tenant #16 reported he/she heard a faint door alarm and it kept buzzing. The tenant went to the door and saw Staff #1 helping Tenant #13 and he/she was out of the building.

Staff #1 indicated approximately a week and a half ago she was taking another tenant to his/her apartment when she heard the alarm. She saw Tenant #13 on both knees and hands on the ground on the cement slab. Staff #1 indicated it was really cold. Tenant #16 came out and the tenant used his/her pull cord to call for assistance because the staff did not have her phone, as it was given to another staff. According to Staff #1, Tenant #16 and the staff helped Tenant #13 up off the ground, while additional staff were on their way. Tenant #16 and Staff #1 brought the tenant back into the building. The on call nurse, Divisional Director of Operations and the tenant's family were called. Staff #1 indicated she did not notice any blue color, skin tears or bruises. Staff #1 indicated Tenant #13 used a walker; however, it was not outside with the tenant. Staff #1 indicated vitals were taken, the tenant was wrapped in blankets and one hour checks were completed all weekend. Staff #1 indicated the tenant did not complain of pain, did not have gait issues, and the tenant's temperature came back up quickly.

At the time of the tenant's elopement he/she was not wearing a Home Free watch. Staff #1 indicated Staff #4 called the Home Free system after the tenant eloped to see why the alarm had not sounded; however, at the time of the elopement, the tenant was not wearing a Home Free watch.

The monitors observed three alarm systems on the Northeast exit door including: the Home Free system, a Radioshack alarm and the main door alarm. The alarm has an instant or delayed setting and had a key that was observed on top of the door frame.

Staff #1 indicated she had training on the alarms when she started. Staff #1 indicated the Northeast door (by apartment #122) did not have a separate alarm on the door. Staff #3 indicated she had training on the Home Free system and training on the new phones. Staff #3 indicated there was a separate alarm on the Northeast door and the alarm went off for a couple of minutes and then stopped. She indicated she did not know about a key to the alarm. Staff #5 indicated the door by apartment #122 (the Northeast) door had a special alarm that had been on the door for awhile. Staff #5 did not know how to shut it off and was not aware if both alarms went off with the special alarm. Staff #7 indicated she had never seen the Radioshack alarm and stated it must have been recently installed. Staff #7 indicated she had not received any training on any of the door alarms and she did not where any of the keys were to the alarms. Staff #8 indicated another direct care staff went over training on the alarms. Staff #8 was not aware there was a separate alarm on the Northeast exit door. Staff #9 had training on doors including how to shut off alarms and use the key pad. Staff #9 was not aware there was a separate alarm on the Northeast exit door. Staff #10 indicated he had no idea who installed the Radioshack alarm and said it was there when he was hired. Staff #10 indicated the separate alarm had a key to shut it off.

A tenant indicated in an interview that one time approximately one month ago, a staff had to get another staff to shut off an alarm going off.

Staff #1, Staff #3, Staff #5 and Staff #7 indicated staff did not ignore alarms when they sounded.

- Regulatory Insufficiency: The program did not consistently provide sufficient trained staff available at all times to fully meet tenants' identified needs. (25.33(1))

I. Life safety – The program shall follow written emergency policies and procedures and structural safety requirements. [321 IAC 25.37]

The program received a regulatory insufficiency related to not following written emergency policies and procedures.

Monitoring Observation: A community meeting with two tenants and two tenant interviews were held. The tenants indicated there had been fire drills, two in the last month. Otherwise, monthly fire drills had occurred recently. One tenant said the fire alarms could be louder and another stated there had been an unscheduled fire drill in the last month and it took staff seven minutes to get the tenants out. The tenant indicated staff knew what to do during the drill.

According to fire drill reports there were drills on 11-26-07; 12-6-07 and 1-3-08. The evacuation list was obtained. (The list obtained on 1-9-08 at 4:25 p.m. had three tenants that were no longer current tenants. The list obtained on 1-9-08 at 4:26 p.m. had a current list of tenants.)

Staff #7 indicated she had not been trained on fire safety and she was not sure of the evacuation list for a fire. Staff #8 indicated she had not been trained on fire safety and was not aware of an evacuation list. Staff #9 indicated she had not been trained on fire safety and she was not sure of an evacuation list for fires.

- Regulatory Insufficiency: The program did not consistently follow written emergency policies and procedures. (25.37(1))

Complaint Allegation #15431: It was alleged staff blocked the Northeast exit door with furniture after a tenant(s) elopement(s).

Monitoring Observation: A community meeting was held with two tenants, as well as, two individual tenant interviews. The tenants indicated furniture, including two chairs and a plant was put in front of the Northeast exit door for approximately one day. The tenants indicated furniture, including two chairs, were placed in front of the Northwest exit door. According to the tenants, these incidents occurred approximately two weeks ago. One tenant reported when the former director was there the furniture was pretty close to the doors. Another tenant indicated a week to two weeks ago a plant and two chairs were put in front of the door to prevent a tenant from leaving.

According to Staff #7, two chairs were put in front of the Northeast exit door for three days so a tenant could not walk through. She moved the furniture because she did not feel it should be there. Staff #7 indicated first/second shift put the furniture in front of the Northeast exit door to prevent a tenant from trying to get out the door. Staff #3 indicated a chair was put in front of the Northeast door because of a malfunctioning alarm. The staff stated this happened in the last year. Staff #5 indicated a couple of chairs and a

plant were put in front of the Northeast exit door to deter a tenant from exiting. Staff #5 indicated approximately six months ago there used to be problems with the Southeast exit door and the couch was in front of the door. Staff #1 indicated a chair was put in front of the door; however, it did not obstruct the whole area. Staff #1 indicated it may have been there for one evening.

- Regulatory Insufficiency: The discharge specified in 7.7.2 shall lead to a free and unobstructed way to the exterior of the building, and such way shall be readily visible and identifiable from the point of discharge from the exit. (LSC 7.7.2.3)

During the course of the investigation, the following information was obtained.

Monitoring Observation: On 1-8-08 the monitors tested the Radioshack alarm on the Northeast exit door. Upon testing the door, the monitors discovered the Radioshack alarm was on a delayed setting. The monitors pushed on the exit door for 15 seconds and the door released. Approximately 25 seconds after the initial alarm went off the Radioshack alarm sounded. The staff who went with the monitors, looked up and found a key (on the top of the door frame) and she shut off the alarm. The staff put the Radioshack alarm on instant after the alarm test.

On 1-9-08 the monitors toured the building with Staff #10. The Southwest exit door was tested. The monitors applied continuous pressure for 15 seconds, twice and the door did not release or alarm. The key pad and door sensor showed a red light indicator. The monitors noticed an alarm sensor plate was not approximated on the Southwest exit door. Staff #10 entered in the code in the Southwest door key pad and the door/alarm worked appropriately. The Northeast exit door when pushed open the door alarm functioned appropriately and the Radioshack alarm instantly alarmed. It was discovered the door did not close completely when pushed open. When the door was swung closed by Staff #10 the door did not completely close. There was approximately a one inch gap between the door frame and the door. When the door did not close, the alarm and key pad showed a red light indicator. It was observed on the upper left corner of the Northeast exit door the door appeared to have a missing magnetic plate. The Southeast exit door alarm functioned appropriately when the door was pushed open; however, the door did not close completely unless the door was swung wide open. When the door was not closed there was approximately a one inch gap between the door frame and the door.

Staff #1 indicated she had training on the alarms when she started. Staff #1 indicated the Northeast door (by apartment #122) did not have a separate alarm on the door. Staff #3 indicated she had training on the Home Free system and training on the new phones. She indicated there was a separate alarm on the Northeast door and the alarm went off for a couple of minutes and then stopped. She did not know about a key to the alarm. Staff #5 indicated the door by apartment #122 (the Northeast) door had a special alarm that had been on the door for awhile. She did not know how to shut it off and was not aware if both alarms went off with the special alarm. Staff #7 indicated she had never seen the Radioshack alarm and stated it must have been recently installed. She indicated she had not received any training on any of the door alarms and she did not know where any of the keys were to the alarms. Staff #8 indicated another direct care staff went over training on the alarms and she was not aware there was a separate alarm on the Northeast exit door. Staff #9 had training on doors including how to shut off alarms and use the key pad; however, she was not aware there was a separate alarm on the Northeast exit

door. Staff #10 indicated he had no idea who installed the Radioshack alarm and said it was there when he was hired. Staff #10 indicated the separate alarm had a key to shut it off.

A tenant indicated in an interview that one time, approximately one month ago, a staff had to get another staff to shut off an alarm.

According to a program document to notify staff of the door and alarm issues raised by the monitors, none of the doors sent an alarm to the phone system consistently when they were opened.

The Director of Risk Management indicated she began coming to the program on a weekly basis on or about 12-3-07. Within a week she personally tested each exit door and each door alarmed properly at that time and she did not need to physically pull any of the doors to lock them. The Director of Divisional Operations had been coming to the program on a weekly basis since 12-3-07 and had tested the exit doors several times and did not identify any problems. The issues with doors and alarms were identified by the monitors on 1-9-08 and the program developed the following protocol in response. The tenants with a GDS of three, four and five were reviewed to determine whether any of them met the triggers for wearing a Home Free watch. Only one tenant that did not already have a Home Free watch met the triggers for having one and this tenant was non-ambulatory and a Home Free watch was not placed on the tenant. Until the issues with the exit doors were resolved the program required staff to perform hourly checks on all tenants with a GDS of three, four or five (even if wearing a Home Free watch). The program provided the hourly flow sheets for each shift. The program also assigned staff to check the doors on an hourly basis.

- Regulatory Insufficiency: Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7. (Reference sections for additional information.) (LSC 7.2.1.6.1)

J. Exit Door Alarm System – A dementia-specific program shall have an operating alarm system connected to each exit door. [25.37(2)]

During the course of the investigation, the following information was obtained.

Monitoring Observation: On 1-8-08 the monitors tested the Radioshack alarm on the Northeast exit door. Upon testing the door, the monitors discovered the Radioshack alarm was on a delayed setting. The monitors pushed on the exit door for 15 seconds and the door released. Approximately 25 seconds after the initial alarm went off the Radioshack alarm sounded. The staff who went with the monitors, looked up and found a key (on the top of the door frame) and she shut off the alarm. The staff put the Radioshack alarm on instant after the alarm test.

On 1-9-08 the monitors toured the building with Staff #10. The Southwest exit door was tested. The monitors applied continuous pressure for 15 seconds, twice and the door did not release or alarm. The key pad and door sensor showed a red light

indicator. The monitors noticed an alarm sensor plate was not approximated on the Southwest exit door (see picture). Staff #10 entered in the code in the Southwest door key pad and the door/alarm worked appropriately. The Northeast exit door when pushed open the door alarm functioned appropriately and the Radioshack alarm instantly alarmed. It was discovered the door did not close completely when pushed open. When the door was swung open by Staff #10 the door did not completely close. There was approximately one inch gap between the door frame and the door. When door did not close, the alarm and key pad showed a red light indicator, when the door was not completely closed. It was observed on the upper left corner of the Northeast exit door the door appeared to have a missing magnetic plate (see picture). The Southeast exit door alarm functioned appropriately when the door was pushed open; however, the door did not close completely unless the door was swung wide open. When the door was not closed there was approximately a one inch gap between the door frame and the door.

Staff #1 indicated she had training on the alarms when she started. Staff #1 indicated the Northeast door (by apartment #122) did not have a separate alarm on the door. Staff #3 indicated she had training on the home free system and training on the new phones. Staff #3 indicated there was a separate alarm on the Northeast door and the alarm went off for a couple of minutes and then stopped. Staff #3 indicated she did not know about a key to alarm. Staff #5 indicated the door by apartment #122 (the Northeast) door had a special alarm that had been on the door for awhile. Staff #5 did not know how to shut it off and was not aware if both alarms went off with the special alarm. Staff #7 indicated she had never seen the Radioshack alarm and stated it must have been recently installed. Staff #7 indicated she had not received any training on any of the door alarms and she did not where any of the keys were to the alarms. Staff #8 indicated another direct care staff went over training on the alarms. Staff #8 was not aware there was a separate alarm on the Northeast exit door. Staff #9 had training on doors including how to shut off alarms and use the key pad. Staff #9 was not aware there was a separate alarm on the Northeast exit door. Staff #10 indicated he had no idea who installed the Radioshack alarm and said it was there when he was hired. Staff #10 indicated the separate alarm had a key to shut it off.

A tenant indicated in an interview one time approximately one month ago a staff had to get another staff to shut off an alarm going off.

According to a program document to notify staff of the door and alarm issues raised by the monitors, none of the doors sent an alarm to the phone system consistently when they were opened.

The Director of Risk Management indicated she began coming to the program on a regular weekly basis on or about 12-3-07. Within a week she personally tested each exit door and each door alarmed properly at that time and she did not need to physically pull any of the doors back. The Director of Divisional Operations had been coming to the program on a regular weekly basis since 12-3-07 and had tested the exit doors several times and did not identify any problems. The issues with doors and alarms were identified by the monitors on 1-9-08 and the program developed the following protocol in response. The tenants with a GDS of three, four and give were reviewed to determine whether any of them met the triggers for wearing a HomeFree watch. Only one tenant that did not already have a HomeFree watch was non-

ambulatory and a Home Free watch was not placed on the tenant, according to the Director of Risk Management. Until the issues with the exit doors were resolved the program required staff to perform hourly checks on all tenants with a GDS of three, four or five (even if wearing a HomeFree watch). The program provided the hourly flowsheets for each shift. The program also assigned staff to check the doors on an hourly basis.

- Regulatory Insufficiency: The program did not consistently have an operating alarm system connected to each exit door in a dementia specific program (25.37 (2))

K. Activities – The program provides appropriate programming for tenants based on individual interests. Programming shall support the service plans, be consistent with the program statement and occupancy policies, and available in writing as required. [321 IAC 25.39]

The program received a regulatory insufficiency in October of 2007 related to providing appropriate programming for each tenant that reflects individual, differences in age, health status, sensory deficits, life style, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills providing opportunities for a variety of types and levels of involvement.

Monitoring Observation: A community meeting with two tenants and two tenant interviews was held at the time of the onsite. The tenants indicated there were enough activities; however, it was difficult to get tenants to participate. A tenant indicated there were not many activities in the evening; however, it did not bother the tenant. One tenant indicated at times activities are scheduled too close to the evening meal and stated 3:00 p.m. would be a better time to begin late afternoon activities. The tenants indicated Staff #6 did a great job of finding activities. They stated Staff #6 was there from 10:00 a.m. - 2:00 p.m. and direct care staff did activities after 2:00 p.m. The tenants stated there were not many activities after 4:00 p.m. unless it was a musical activity. Two tenants stated they were not sure if there were enough dementia specific activities. One tenant indicated there could be more dementia specific activities including more ball toss, ring toss type activities. One tenant indicated those tenants with dementing illness participated in the same activities as those without dementing illness.

Staff #5 indicated there had not been improvement with activities since last visit and she had never seen a 6:00 p.m. activity. Staff #5 indicated if someone else comes into the program the 6:00 p.m. activity takes place; however, if not the activity does not get completed. Staff #1 indicated there were sufficient activities for those with dementing illness. Staff #1 indicated activities had improved since the last visit. Staff #3 stated there had been improvement with activities. Staff #1 indicated a volunteer or Staff #6 was needed on the weekends for activities due to time issues and indicated she felt pinched for time in the evening. Staff #1 indicated Staff #6 leaves scheduled activities for evenings and weekends.

Staff #6 indicated her hours were changed this week and she currently works Monday, Tuesday and Friday from 10-2:00 p.m. and Wednesday and Thursday from 10-4:30 p.m. for a total of 25 hours a week. Staff #6 was not sure if this was a permanent change and previously worked 20 hours a week. She indicated she developed both general population and dementia specific activity calendars. In the evening, one direct care staff was responsible for activities and she was pretty confident the activities were occurring.

Staff #6 indicated there was a good variety of activities and she had a really good grasp on each person as an individual. She indicated she started tracking activities for those tenants with dementing illness on 1-8-08 through 1-11-08.

- Regulatory Insufficiency: None noted.

L. Structural requirements – The structure of the program shall be designed and operated to meet the needs of the tenants. The buildings and grounds shall be well-maintained, clean, safe and sanitary.

Complaint Allegation #13835: The program received a regulatory insufficiency in the October 2007 report related to consistently maintaining the building in a clean, safe and sanitary manner.

Monitoring Observation: At 5:06 p.m. on 1-8-08 the monitors observed the area in the main kitchen where mold had previously been discovered and the area appeared to be repaired. A picture of the area was taken (picture #006). According to the program's maintenance log on 10-19-07 the mold spot was scraped and a stain treatment was applied.

A community meeting with two tenants and two tenant interviews were held at the time of the onsite. The tenants stated Staff #10 was the best maintenance staff they have had. They stated he was very efficient and did a good job. One tenant indicated things are repaired quickly now. Another tenant indicated Staff #10 was terrific and there was a prompt response to maintenance issues.

- Regulatory Insufficiency: None noted.

M. Other – The provisions of this section address the program's noncompliance with other applicable statutory and administrative rule requirements.

Complaint Allegation #15431: It was alleged staff was rude to Tenant #17 regarding eating.

Monitoring Observation: Tenant #17 was discharged on 1-7-08.

A community meeting with two tenants and two tenant interviews were held at the time of the onsite. The tenants indicated they had not heard staff being inappropriate or rude to any tenants.

Staff #3 indicated she had not heard anyone who was rude to Tenant #17 regarding food; however, the tenant would eat until he/she was sick. Staff would tell the tenant no, at times, when the tenant asked for food. Staff #7 indicated the tenant would eat puzzle pieces and always wanted something to eat. She indicated, at times, the tenant vomited and ate the vomit and that staff to staff, they made light of it and indicated staff would mimic the tenant and eating issues. Staff #7 indicated no comments were made to Tenant #17 or in front of other tenants. Staff #1 indicated there were no inappropriate comments made towards Tenant #17; however, staff were at times authoritative with the tenant after telling him/her no, regarding food, five or six times. Staff #5 indicated she had not heard anyone talk inappropriately to Tenant #17.

- Regulatory Insufficiency: The program did not assure that the dignity of the tenant was maintained. (231C.1(1))

During the course of the complaint investigation and revisit, the following information was obtained.

Monitoring Observation: Tenant file reviews, staff interviews, a community meeting and monitors observations indicated the program did not consistently follow the written the Plan of Correction (POC) that was submitted on December 21, 2007 in regard to the complaint investigation and revisits conducted on October 3, 4 & 5, 2007.

- Regulatory Insufficiency: The program did not consistently follow the POC submitted to the Department in response to a previous complaint investigation. (26.2(6)a)

Dated this 14th day of April, 2008.

April 11, 2008, 2008

Chris Nothaft
Certification Coordinator-Eastern Iowa
Adult Services Bureau
Health Facilities Division
Department of Inspections and Appeals
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319-0083

Dear Ms. Nothaft:

This letter is in response to the request for additional information # 12590R2, #12594R2, #13835R, and #15431 completed at the Iowa City Bickford Cottage on January 8, 9, 10, & 11, 2008.

The following documents serve as the updated written Plan of Correction to address the regulatory insufficiencies identified during that visit.

If you have additional questions, please contact me at (319)-351-3200
Thank you for your time and consideration in this matter.

Sincerely,

Christina Bricker, Director
Iowa City Bickford Cottage

Plan of Correction
Iowa City Bickford Cottage
March 4, 2008

A. Occupancy Agreement

Regulatory Insufficiency: The program does not consistently obtain signed occupancy agreements for all residents prior to taking occupancy.

Plan of Correction:
The insufficiency will be corrected as follows:

- Bickford Cottage will follow policy and ensure that all residents will have an occupancy agreement signed prior to taking occupancy, effective immediately.
- Resident #14 was transferred to another facility on 2/2/2008. An occupancy agreement was not signed prior to that transfer as the resident never returned to Bickford Cottage Iowa City.

The program will take the following action to protect the residents from similar situations:

- All new resident admissions will have the occupancy agreement signed prior to taking residence at Iowa City Bickford Cottage.

The following measures will be taken to assure the problem does not recur:

- The Divisional Director of Operations will ensure that training is provided to the Director regarding the need for occupancy agreements to be signed prior to the resident moving in. This will be completed by 3/1/2008.

The program will monitor performance to ensure permanent solutions in the following manner:

- The Divisional Director of Operations will audit resident documents at least twice a year, to ensure Occupancy Agreements are signed prior to the resident moving in.

B. Evaluation of Tenant

Regulatory Insufficiency: The program does not consistently complete cognitive, health and functional evaluations within thirty days and as needed.

Plan of Correction:
The insufficiency will be corrected as follows:

- Bickford Cottage will evaluate functional, cognitive and health status prior to admission, within thirty days of occupancy, on a scheduled basis, as well as needed due to change in resident's condition to determine their continued eligibility and the need for modifications in services provided.
- Resident #5–Evaluations are updated and complete **(attachment #1)**
- Resident #7–Resident is deceased as of 2/11/2008.
- Resident #8–Evaluations are updated and complete.**(attachment #2)**
- Resident #13–Evaluations are updated and complete and a Homefree watch is in use with the resident.**(attachment #3)**

- Resident #14–Resident has been discharged as of 2/2/2008.

The program will take the following actions to protect residents from similar situations:

- The Divisional Director of Resident Services provided education to the current RNC regarding completion of evaluations on residents and as relates to the requirements for updates with changes in resident's conditions and care needs, as of 1/23/ 2008.

The following measures will be taken to ensure the problem does not recur:

- Routine communication between the Director, RNC and front line staff will be initiated immediately for notification of any change in resident's condition or care needs, to ensure changes are assessed and addressed in a timely manner.

The program will monitor performance to ensure permanent solutions in the following manner:

- The Divisional Director of Resident Services will review resident records at least two times per year for evidence of change in condition/care needs and the initiation of the evaluation process.

E. Service Plan

Regulatory Insufficiency: The program did not consistently update service plans for tenants, with a change in condition.

Plan of Correction:

The insufficiency will be corrected as follows:

- Bickford Cottage will update Service Plans to reflect resident's current needs upon a change in condition.
- Resident #5–Service plan is updated and reflects the current and identified needs of the resident.**(attachment #4)**
- Resident #7–Resident is deceased as of 2/11/2008.
- Resident #8–Service Plan is updated and reflects the current and identified needs of the resident.**(attachment #5)**
- Resident #10–Service plan is updated and reflects the current and identified needs of the resident including catheter care. **(attachment #6)** Per DIA request, Resident #10 catheterization chart will be faxed to DIA each Friday beginning 2/29/2008 and until such time that DIA discontinues the request or resident would be discharged, deceased, or discontinues receiving catheterization per physician's order, whichever occurs first.
- Resident #13–Service plan is updated and reflects the current and identified needs of the resident.**(attachment #7)**
- Resident #14–Discharged as of 2/2/2008.

The program will take the following actions to protect residents from similar situations:

- The Divisional Director of Resident Services provided instruction on the service plan process and state regulatory requirements to the new acting RNC on 1.23.08.

The following measures will be taken to ensure the problem does not recur:

- Communication between the Director, RNC and front line staff will occur at a minimum of monthly or as indicated basis through verbal interactions to monitor changes in resident's care needs, as well as the use of care notes. If there is a change in the resident's status, evaluations will be completed with the changes incorporated into the updated Service Plan.

The program will monitor performance to ensure permanent solutions in the following manner:

- The Divisional Director of Resident Services will audit the residence, at least twice a year, for evidence of changes in resident's needs and completion of the updated Service Plan.

Regulatory Insufficiency: The program did not consistently develop service plans that meet the identified needs of the residents.

Plan of Correction:

The insufficiency will be corrected as follows:

- Bickford Cottage will develop and update Service Plans to meet the identified needs of a resident.
- Resident #5–Service plan is updated and reflects the current identified needs of the resident.**(attachment #4)**
- Resident #7–Resident is deceased as of 2/11/2008.
- Resident #8–Service Plan is updated and reflects the current identified needs of the resident.**(attachment #5)**
- Resident #10–Service plan is updated and reflects the current identified needs of the resident including catheter care. **(attachment #6)** Per DIA request, Resident #10 catheterization chart will be faxed to DIA each Friday beginning 2/29/2008 and until such time that DIA discontinues the request or resident would be discharged, deceased, or discontinues receiving catheterization per physician's order, whichever occurs first.
- Resident #13–Service plan is updated and reflects the current identified needs of the resident.**(attachment #7)**
- Resident #14–Discharged as of 2/2/2008.

The program will take the following actions to protect residents from similar situations:

- The Divisional Director of Resident Services provided instruction on the service plan process and state regulatory requirements to the new acting RNC on 1.23.08.

The following measures will be taken to ensure the problem does not recur:

- Communication between the Director, RNC and front line staff will occur at a minimum of monthly or as indicated basis through verbal interactions to monitor changes in resident's care needs, as well as the use of care notes. If there is a change in the resident's status, evaluations will be completed with the changes incorporated into the updated Service Plan, so that the Plan meets the identified needs of the resident.

The program will monitor performance to ensure permanent solutions in the following manner:

- The Divisional Director of Resident Services will audit the residence, at least twice a year, for evidence of changes in resident's needs and completion of the updated Service Plan, identifying the current needs of the resident.

Regulatory Insufficiency: The program did not consistently develop service plans in accordance with 25.23(1) and 25.23(2) and designed to meet the specific service needs of the individual resident.

Plan of Correction:

The insufficiency will be corrected as follows:

- Bickford Cottage will develop and update Service Plans to reflect resident's needs upon a change in condition, meet the identified needs of a resident, and designed them to meet specific service needs of an individual resident.
- Resident #5–Service plan is updated and reflects the current and identified needs of the resident.**(attachment #4)**
- Resident #7–Resident is deceased as of 2/11/2008.
- Resident #8–Service Plan is updated and reflects the current and identified needs of the resident.**(attachment #5)**
- Resident #10–Service plan is updated and reflects the current and identified needs of the resident including catheter care. **(attachment #6)** Per DIA request, Resident #10 catheterization chart will be faxed to DIA each Friday beginning 2/29/2008 and until such time that DIA discontinues the request or resident would be discharged, deceased, or discontinues receiving catheterization per physician's order, whichever occurs first.
- Resident #13–Service plan is updated and reflects the current and identified needs of the resident.**(attachment #7)**
- Resident #14–Discharged as of 2/2/2008.

The program will take the following actions to protect residents from similar situations:

- The Divisional Director of Resident Services provided instruction on the service plan process and state regulatory requirements to the new acting RNC on 1.23.08.

The following measures will be taken to ensure the problem does not recur:

- Communication between the Director, RNC and front line staff will occur at a minimum of monthly or as indicated basis through verbal interactions to monitor changes in resident's care needs, as well as the use of care notes. If there is a change in the resident's status, evaluations will be completed with the changes incorporated into the updated Service Plan.

The program will monitor performance to ensure permanent solutions in the following manner:

- The Divisional Director of Resident Services will audit the residence, at least twice a year, for evidence of changes in resident's needs and completion of the updated Service Plan.

F. **Medications:**

Regulatory Insufficiency: The program does not consistently follow an acceptable medication/treatment protocol as required.

Plan of Correction:

The insufficiency will be corrected as follows:

- Iowa City Bickford Cottage will ensure that all CMAs/CNAs consistently follow acceptable medication protocol.
- Effective immediately, Bickford Cottage will have trained and delegated staff available at all times to provide medication administration and to perform nurse delegated tasks as they arise to meet resident's needs.
- Staff #12 is no longer employed with Bickford Cottage of Iowa City.
- All appropriate staff received additional Medication Administration Delegation by 2.27.08.
- Resident #7: Deceased 2.11.08
- Resident #8: MAR contains signatures indicating leg elevation has been completed.
- Resident # 9: Deceased 3.5.08.
- Resident # 10: Current intermittent catheterization information and documentation are recorded on a flow sheet and submitted weekly as requested to the state. Blood pressures are recorded as ordered on the MAR. Documentation of RNC and physician notification is contained in the care notes.
- Resident # 14: Discharged as of 2.2.08.

The program will take the following actions to protect residents from similar situations:

- Staff delegation training has been documented on Bickford Cottage delegation forms, with copies maintained in the individual staff personnel files, as well as in a delegation notebook kept in the med room for staff access.
- All new staff will have delegation training completed and documented prior to performing any nurse delegated tasks.

The following measures will be taken to ensure the problem does not recur:

- RNC performs weekly Medication Audits, which include review of medication delivery system to see that medication has been administered correctly and review of the Medication Administration Record (MAR) to ensure that documentation is complete.
- RNC, per request of DIA, will fax weekly beginning 2/29/2008, Medication Audit form to DIA until such time that request is discontinued by DIA.
- Staff have been retrained on the catheterization process and expectations to meet the physician's orders
- A new catheterization flow sheet has been developed and is in use to assist the staff in documenting appropriately the physician's orders in regard to the catheterization.
- RNC, per request, will fax to DIA weekly beginning 2/29/2008, catheterization charting of Resident #10 until such time that request is discontinued by DIA, the resident is discharged, resident becomes deceased, or catheterization is discontinued per physician order, whichever comes first.
- RNC will monitor results of monthly weights and vitals to ensure task has been completed.

The program will monitor performance to ensure permanent solutions in the following manner:

- RNC will include safe medication practice with all new CMA's during new orientation training and provide nurse delegation if appropriate, and prior to staff performing any nurse delegated tasks.
- The RNC will monitor staff performance of medication administration through the weekly Medication audits, which are also submitted to the Divisional Director of Resident Services and the Sr. VP of Resident Services.

G. Nurse Review:

Regulatory Insufficiency:

The program does not consistently assess and document the health status of each tenant, make recommendations and referrals as appropriate, and monitor progress on previous recommendations at least every 90 days, or if there are changes in health status.

Plan of Correction:

The insufficiency will be corrected as follows:

- The RNC will assess and document the health status of each resident, make recommendations and referrals as appropriate, and monitor the progress on previous recommendations, at least every 90 days, or if there are changes in the resident's health status.
- Resident #5: Nurse Review completed on 3.4.08.
- Resident # 7: Deceased 2.11.08.
- Resident # 8: Nurse Review completed on 3.13.08.
- Resident # 13: Nurse Review completed on 2.27.08.
- Resident #14: Discharged 2.2.08

The program will take the following actions to protect residents from similar situations:

- The Divisional Director of Resident Services provided education to the new acting RNC in January and February 2008, with regard to the need for nurse review, documentation of monitoring of resident's condition, and what is to be contained in Nurse Review documentation.

The following measures will be taken to ensure the problem does not recur:

- The RNC will complete a Nurse Review on each resident, at a minimum, every 90 days.

The program will monitor performance to ensure permanent solutions in the following manner:

- The Divisional Director of Resident Services will audit resident records, at least twice a year, for evidence that the RNC is documenting the monitoring of residents and their care needs through their stay and with any changes in condition.

H. Staffing

Regulatory Insufficiency: The program did not consistently provide sufficient trained staff available at all times to fully meet tenant's identified needs.

Plan of Correction:
The insufficiency will be corrected as follows:
- Bickford Cottage Director will ensure that sufficiently trained staff is on duty at all times to meet the resident's identified needs.
- The RNC will ensure that any staff providing resident care has had nurse delegation for any delegated tasks assigned.

The program will take the following actions to protect residents from similar situations:
- Nurse delegation will be provided to ensure residents have staff available and delegated to meet their needs. Delegation will include education, written instruction, observation, and return demonstration. All appropriate staff will have delegation completed on catheter care, blood sugar monitoring, and medication administration, as well as any other tasks provided that require nurse delegation.

The following measures will be taken to ensure the problem does not recur:
- All new staff will have nurse delegation completed and documented prior to performance of any nurse delegated task.

The program will monitor performance to ensure permanent solutions in the following manner:
- The Divisional Director of Resident Services will audit, at least twice a year, nurse delegation for appropriate delegation and documentation.

I. Life Safety

Regulatory Insufficiency: The program does not consistently follow written emergency policies and procedures.

Plan of Correction:
The insufficiency will be corrected as follows:
- Director will utilize the Emergency Handbook for scheduling and documenting all emergency policies and procedures.
- A current resident evacuation list will be posted in the Emergency Handbook to include resident information about any assistance needed to evacuate in case of an emergency.
- All current staff will be trained in fire safety procedures and use of the Emergency Handbook.

The program will take the following actions to protect residents from similar situations:
- All new staff will be educated on emergency procedures at the time of orientation.
- The building maintenance person will check for proper operation of the doors five times per week and take immediate steps to remedy any improper operation.

- The Director will take any necessary actions to protect residents in the situation where a door is not functioning appropriately.

The following measures will be taken to ensure the problem does not recur:
- Staff received follow-up training on 2/29/2008 with regard to Life Safety policies and procedures including fire drills, evacuation of residents and other emergency policies.

The program will monitor performance to ensure permanent solutions in the following manner:
- The Divisional Director of Operations will audit, at least twice a year, to ensure that emergency fire and evacuation drills are being held on required, scheduled basis.
- The Director will ensure that the building maintenance person is performing regular checks of the exit door operation.

Regulatory Insufficiency: The discharge specified in 7.7.2 shall lead to a free and unobstructed way to the exterior of the building, and such way shall be readily visible and identifiable from the point of discharge from the exit.

Plan of Correction:
The insufficiency will be corrected as follows:
- Director will utilize the Emergency Handbook for scheduling and documenting all emergency policies and procedures.
- No exit door will be blocked or obstructed and will be readily visible and identifiable from the point of discharge from the exit.

The program will take the following actions to protect residents from similar situations:
- All new staff will be educated on emergency procedures/life safety issues during orientation.

The following measures will be taken to ensure the problem does not recur:
- Staff received follow-up training on 2/29/2008 with regard to Life Safety policies and procedures including fire drills, evacuation of residents and other emergency policies, as well as the need to be sure exits are never obstructed.

The program will monitor performance to ensure permanent solutions in the following manner:
- The Divisional Director of Operations will audit, at least twice a year, to ensure that emergency fire and evacuation drills are being held on required, scheduled basis.

Regulatory Insufficiency: Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7.

Plan of Correction:
The insufficiency will be corrected as follows:

.Per DIA request, an outside entity will examine the exit doors for code compliance and the report from the outside entity will be submitted to DIA and the State Fire Marshall's office.

The program will take the following actions to protect residents from similar situations:

- All new staff will be educated on proper operation of the doors at the time of orientation.

The following measures will be taken to ensure the problem does not recur:

- The building maintenance person will check for proper operation of the doors on a weekly basis and take immediate steps to remedy any improper operation.

The program will monitor performance to ensure permanent solutions in the following manner:

- The Divisional Director of Operations will audit, at least twice a year, to ensure that emergency fire and evacuation drills are being held on required, scheduled basis.
- The Director will ensure that the building maintenance person is performing regular checks of the exit door operation.

J. Exit Door Alarm System

Regulatory Insufficiency: **The program did not consistently have an operating alarm system connected to each exit door in a dementia specific program.**

Plan of Correction:

The insufficiency will be corrected as follows:

- The program will consistently have a functioning alarm system connected to each exit door.
- The Divisional Director of Operations, building Maintenance Person, and the Director of Risk Management performed multiple checks over a period from 1/12/08 thru 2/15/08 to ensure that all alarm systems as required on exit doors were functioning properly.

The program will take the following actions to protect the residents from similar situations:

- Weekly tests of the exit door alarms will be performed and recorded.

The following measures will be taken to ensure the problem does not recur:

- Any improper operation of the exit door alarms will be immediately reported to the Director and the problem will be remedied immediately or the policy for safety will be initiated until the problem is remedied.

The program will monitor performance to ensure permanent solutions in the following manner:

- The Director will ensure that weekly tests are performed and recorded as to the proper functioning of the exit door alarms.
- The Divisional Director of Operations will monitor compliance on a quarterly basis.

M. Other

Regulatory Insufficiency: The program did not assure that the dignity of the tenant was maintained.

Plan of Correction:
The insufficiency will be corrected as follows:
- Residents of Bickford Cottage will be treated with respect and dignity.

The program will take the following actions to protect residents from similar situations:
- The Director, RNC and Staff will all be re-trained on 2/29/08. Resident's rights were reviewed with the staff, as well as techniques and interventions for appropriate staff interactions with dementia residents.

The following measures will be taken to ensure the problem does not recur:
- The Director and RNC will monitor staff interactions to ensure that their conduct respects the dignity of the residents.

The program will monitor performance to ensure permanent solutions in the following manner:
- Divisional Managers will observe staff-resident interactions to ensure that staff is respectful of residents and treating them in a dignified manner.

Regulatory Insufficiency: The program did not consistently follow the POC submitted to the Department in response to a previous complaint investigation.

Plan of Correction:
The insufficiency will be corrected as follows:
- Bickford Cottage will implement the current Plan of Correction as it is submitted to the State.

The program will take the following actions to protect residents from similar situations:
- The Director, RNC and Staff will all be re-educated by 2/29/08 on what is expected of them, and what their part entails, in regard to the Plan.

The following measures will be taken to ensure the problem does not recur:
- The Director and RNC will have routine conference calls with Divisional managers and corporate staff to monitor their performance in meeting the regulations for Assisted Living programs.

The program will monitor performance to ensure permanent solutions in the following manner:
- Divisional Managers will monitor Director, RNC and staff performance by observing performance and plan implementation in the program to ensure compliance with State regulations during visits minimally two times a year.