IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

September 30, 2008

Bonnie Smith, Director
Bickford Cottage Assisted Living
1100 Linden Drive
Marion, IA 52302-7714

RE: I. Final Recertification Monitoring Evaluation 2nd Revisit
II. Immediate Sanction – Conditional Operation
III. Civil Penalty
IV. Hearings and Appeals
V. Conclusion

Dear Ms. Smith:

I. Final Recertification Monitoring Evaluation 2nd Revisit – Bickford Cottage, Marion, IA

Enclosed is the **Final Recertification Monitoring Evaluation 2nd Revisit** 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: Evaluation of Tenant, Criteria for Exclusion of Tenants, Service Plan, Nurse Review and Other.

DIA is denying the Request for Reconsideration in regard to Criteria for Exclusion of Tenants due to the two tenants being outside the criteria for retention on the day of DIA's visit. A waiver was not requested until the day after DIA's visit. We are accepting the Plan of Correction (POC).

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 August 6, 2008, Bickford Cottage, Marion's

Conditional Certificate, issued December 5, 2007, is extended. The program's Conditional Certificate is to continue until such time as the program is in compliance, but in no case longer than December 5, 2008. The Conditional Certificate is issued as an alternative to denial, suspension or revocation pursuant to Iowa Code section 231C.10(2).

In addition, the program will not be allowed to admit new tenants until such time as the restriction and/or Conditional Certificate is lifted by the department. The program will also be required to provide documentation of the completion of Assisted Living Management Training for the Nurse and Program Director, thirty day nurse reviews are required to be submitted and any new staff are required to have documented nurse delegation training submitted to the DIA. The Conditional Certificate and sanctions are effective immediately. While effective immediately, the program may appeal these sanctions by filing an appeal within 30 days of issuance of the final 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

Bickford Cottage, Marion's Conditional Certificate will continue until such time as the program is in compliance, but in no case longer than December 5, 2008. In addition, the program will not be allowed to admit new tenants until such time as the restriction and/or Conditional Certificate is lifted by the department. The Program Director and Registered Nurse are required to complete Assisted Living Management Training and submit documentation of such, the nurse is required to complete thirty day nurse reviews and submit them to DIA, and the program must submit documentation to DIA of all nurse delegated training for new staff. Bickford Cottage is being assessed a $10,000.00 civil money penalty.

The Request for Reconsideration is denied. The Plan of Correction is accepted. 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,

Rose Breeden for

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Recertification 2nd Revisit Report

Assisted Living Program:

Bonnie Smith, Director
Bickford Cottage Assisted Living
1100 Linden Drive
Marion, IA 52302-7714

Date of Investigation:

August 6, 2008

Monitor(s):

Hal Chase, RN BSN MPH
Stephanie Cummins, SW MA

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 recertification 2nd revisit on-site was conducted at Bickford Cottage Assisted Living in Marion on August 6, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	21
Current number of tenants with cognitive disorder:	10
Total Population:	31

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition 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 holds itself out as providing specialized care in a dedicated setting:	7
Current number of tenants without cognitive disorder:	0
Total Population:	7

***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 Regulatory Insufficiencies in the areas of: Evaluation of Tenants, Service Plans, Medications and Other this certification period.

The November 13, 2007 Recertification Monitoring visit resulted in issuance of a Conditional Certificate, the program's Director and Registered Nurse being required to attend management training, 30 day nurse reviews being completed by the program and documentation of nurse delegation with any new staff. The program was also required to pay a civil penalty of $1,500.00.

The April 8, 2008 Recertification Monitoring Revisit resulted in continuance of a Conditional Certificate, submission of documentation of the program's Director and Registered Nurse having enrolled and/or attended management training, 30 day nurse reviews being completed by the program and submitted to DIA and documentation of nurse delegation with any new staff being submitted to DIA. The program was also required to pay a civil penalty of $4,000.00.

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

A. 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 at the time of the April 2008 visit, regarding Tenants #5, #6, #7, #8 and #9 related to not consistently completing cognitive, health and functional evaluations, as needed, with a change in the tenant's condition.

Monitoring Observation: Tenant #6 was discharged on 4-21-08 and Tenant #7 was discharged on 7-4-08.

Tenant #5, a 74 year old, was admitted on 5-27-05 and diagnoses include: Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Osteoporosis, Hyperlipidemia, Renal Insufficiency, Bi-Polar Disorder, Peripheral Neuropathy, Cancer of the Uterus, and Degenerative Disc Disease. The current Mini Mental Status Exam (MMSE) had a scoring tool to denote cognitive risk. According to Incident Reports from 5-1-08 to 8-3-08, the tenant had over 10 falls. The tenant had four falls from 6-29-08 to 6-30-08, including three falls in a 30 minute period on 6-29-08. Evaluations were completed on 6-27-08 and on 7-8-08. Evaluations were not completed as needed, a cognitive evaluation completed 7-8-08 and a health evaluation completed 7-15-08 were completed due to increased falls and concerns the tenant wanted to stay in his/her apartment. A functional evaluation was not completed at this interval. The tenant had five falls from 7-16-08 to 8-3-08. According to progress notes dated 7-22-08, there was a request for a Urinary Analysis (UA) and Physical Therapy (PT) evaluation and possible treatment. According to progress notes dated 8-6-08, the tenant did not accept PT or Occupational Therapy (OT) and refused to participate in therapy services. Evaluations were last completed on 7-15-08, prior to the most recent five falls and the request for PT. Evaluations were not completed as needed.

Tenant #9, an 85 year old, was admitted on 3-14-08 and has diagnoses of: Alzheimer's Disease, History of Urinary Tract Infections, History of Left Total Hip Replacement and History of Constipation. Functional, cognitive and health evaluations were appropriately completed with a change in health status.

- Regulatory Insufficiency: The program did not consistently evaluate each tenants' functional, cognitive and health status as needed to determine the tenants' continued eligibility for the program and to determine any modifications to the services needed. (25.23(2))

B. 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]

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

Monitoring Observation: Tenant #17, an 84 year old, was admitted to respite on 2-8-08 through 2-16-08 and signed an occupancy agreement as a permanent tenant on 6-6-08 and was admitted to the program on 6-7-08. The tenant has diagnoses of: Alzheimer's

Disease, Hypercholesterolemia, Hypertension (HTN), Gastroesophageal Reflux Disease (GERD), Prostate Cancer, Insomnia and Arthritis. The tenant was staged at a four on the GDS, which indicated moderate cognitive decline. Progress notes of 2-11-08 through 2-16-08 indicated the tenant tried to leave the building, setting off door alarms. The tenant was readmitted to respite on 4-6-08 through 5-7-08. Progress notes of 4-6-08 through 5-5-08 indicated numerous attempts to elope from the program. On 5-5-08 the tenant eloped from the program and was found at a park approximately one mile away. Progress notes of 6-9-08 through 7-31-08 indicated numerous attempts to elope from the program, twice by trying to climb a fence and also by opening doors and windows trying to get out. An incident report of 6-11-08 indicated the tenant exited the building. Staff searched the general area and did not find the tenant. Staff searched the grounds, found the tenant and escorted the tenant back into the building. Progress notes of 6-12-08 indicated the tenant walked into an apartment where staff was helping a female tenant. Tenant #17 was naked. The tenant asked staff if "they wanted to make love. Patted CNA on bottom twice. Urinated in res sink. Several times res almost lost balance. ...said 'I'm drunk.' 'I drank wiskey.' Inc X2. When using toilet, res stretching penis and swinging it while urinating setting urine all over mirror, floor, and wall." An incident report of 7-5-08 indicated the tenant was physically aggressive toward staff by hitting a staff person's ears with both open hands. An incident report of 7-26-08 indicated the tenant was physically aggressive toward a tenant, holding a female tenant's wrist against a counter. The tenant's physician was contacted by the monitor and stated he had seen the tenant in March, 2008. The physician stated the tenant had eloped from the program and continues to exit seek and he believes the tenant needs more supervised care than the program can offer.

Tenant #18, a 78 year old, was admitted on 5-21-08 and diagnoses include: Dementia, Anxiety and Urinary Tract Infection (UTI). The tenant was staged at a six on the GDS, which indicated severe cognitive decline. The tenant resided in the dementia unit.

Staff #1 and Staff #5 indicated staff were harmed by Tenant #18. Staff #1 stated she was grabbed by the shoulder and thrown against the door on 6-15-08. Staff #1 indicated the tenant had multiple incidents of physical aggression towards her, other staff and tenants. Staff #1 indicated the tenant was started on Haldol and was not aggressive this week. Staff #5 stated the tenant grabbed staffs' arms and pushes them. Staff #5 indicated this behavior happened daily and the tenant was resistant to cares. According to Staff #5, the tenant has been aggressive this week and the behavior occurs mostly in the evenings. Staff #5 indicated the tenant had a new medication; however, there have been no changes in behaviors. Staff #5 indicated the tenant is on Haldol; however, it does not help and the tenant continues to be agitated. Staff #5 indicated the tenant grabbed another tenant one time.

Progress notes dated 7-4-08 through 8-02-08 detail the tenant's exit seeking behaviors, being physically aggressive and being resistant to cares. According to notes dated 7-5-08 the tenant became aggressive and hit staff in the head with both hands. The tenant was then unresponsive to verbal requests. The tenant left via ambulance and was admitted to the hospital. Progress notes dated 7-5-08 at 10:00 p.m. indicated the tenant was admitted for treatment of a UTI. According to progress notes dated 7-9-08 the tenant was seen in the hospital by a program nurse and the tenant was in a tent type enclosure to inhibit wandering off the unit. The tenant returned to the program on 7-15-08. On 7-23-08 the tenant's doctor ordered Haldol, 5 mg, every four hours, as needed. According to progress

notes dated 7-26-08 at 9:30 p.m., staff observed Tenant #18 holding onto another tenant's wrists up against a counter. According to progress notes dated 7-26-08 at 10:00 p.m., the nurse discussed with the doctor the tenant's aggressive behavior and possible follow up of the UTI. The doctor stated, "...has behaviors...has dementia ...has already been evaluated." The nurse informed the doctor, the tenant's behavior needed further evaluation and stated the program's dementia unit was not a behavioral unit and that harming others was not okay. On 7-26-08 at 10:00 p.m., the doctor ordered Lorazepam, 1 mg every four hours, as needed and to give one immediately. On 7-28-08 the nurse reported to the doctor's nurse that the tenant's behavior was not improved since 7-26-08. The nurse requested the tenant be evaluated at Adult Psychiatry or the Emergency Room (ER). The program nurse indicated to the doctor's nurse that the tenant could no longer remain at the program due to uncontrollable aggressive behavior. The doctor denied a request for evaluation and ordered the program to increase the tenant's medication, Abilify, to 20 mg. According to a physician's order dated 8-1-08, the tenant's aggressive behavior had improved with PRN Haldol use over the last 72 hours with the exception of two incidences where he/she was physically aggressive to staff. Haldol, 5 mg by mouth, was utilized approximately every four to five hours except when the tenant was sleeping.

Progress notes discussed conversations with the tenant's spouse regarding potential discharge due to behaviors; however, a 30 day notice was not given at the time of the on-site.

The tenant's doctor's office was contacted on 8-12-08. The doctor's nurse indicated the tenant was last seen by the doctor on 6-18-08. The doctor's nurse stated the doctor felt the tenant was appropriate for a dementia or Alzheimer's unit in a nursing facility. The doctor's nurse indicated on 8-8-08 the tenant's Haldol, 5 mg, had been discontinued and the tenant was started on Risperdal, .025 mg, twice daily. The doctor's nurse indicated the tenant benefited from living at the program.

- Regulatory Insufficiency: The program did not exclude Tenant #17 and Tenant #18, who are a danger to self or other tenants or staff, including but not limited to, a tenant who: (1) Despite intervention chronically wanders into danger, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression or (2) Displays behavior that places another tenant at risk. (25.23(3))

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

The program had received regulatory insufficiencies at the time of the April 2008 visit regarding Tenants #6, #7, #8 and #9 related to not consistently updating service plans when the tenant had a change in condition and not consistently developing service plans that identified the needs of the tenants and the tenant's request for assistance and expected outcomes; and not identifying services and cares to be provided pursuant to the occupancy agreement with the tenant and the service providers, if other than the program.

Monitoring Observation: Tenant #6 was discharged on 4-21-08. Tenant #7 was discharged on 7-4-08.

Tenant #8's service plan of 6-27-08 indicated staff were to provide verbal cues and standby assistance with a wheeled walker and were to encourage the tenant to stand

straight when ambulating but it did not establish interventions related to the tenant's refusal of evening medications.

Tenant #9's service plan was appropriately updated on 7-3-08 and was reflective of the tenant's identified needs.

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

Tenant #5 had four falls from 6-29-08 to 6-30-08, including three falls in a 30 minute period on 6-29-08. The service plan was updated on 6-27-08 and on 7-8-08. The service plan was not updated, as needed, a cognitive evaluation completed 7-8-08 and a health evaluation completed 7-15-08 were completed due to increased falls and concerns the tenant wanted to stay in his/her apartment. A functional evaluation was not completed at this interval. The service plan was updated on 7-8-08; however, was not based on the functional assessment. The tenant had five falls from 7-16-08 to 8-3-08. According to progress notes dated 7-22-08, there was a request for a Urine Analysis (UA) and PT evaluation and possible treatment. According to progress notes dated 8-6-08 at 11:00 a.m., the tenant refused to accept PT/OT services. The service plan was last updated on 7-15-08, prior to the most recent five falls and request for PT. The service plan was not updated, as needed.

Tenant #18's service plan was updated on 7-29-08; however, the service plan was not signed by a nurse, two staff and the tenant or the tenant's legal representative.

- Regulatory Insufficiency: The program did not, when the tenant needed personal care or health-related care, update the service plan, as needed, by a multidisciplinary team that consists of no fewer than three individuals, including a health care professional and other staff appropriate to meet the needs of tenant, in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. (25.28(3))

- Regulatory Insufficiency: The program did not individualize the service plan and did not indicate, at a minimum; the tenant's identified needs and the tenant's request for assistance and expected outcomes and did not identify any services and care to be provided pursuant to the occupancy agreement with the tenant and the service providers if other than the program. (25.28(4))

- Regulatory Insufficiency: The program did not consistently develop a service plan for each tenant based on evaluations conducted in accordance with 25.23(1) and 25.23(2). (25.28(1))

D. 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 at the time of April, 2008 visit related to the administration of medications being provided by an Iowa-licensed registered nurse or advanced registered nurse practitioner registered in Iowa or the authorized agent in accordance with 655—subrule 6.2(5) and 655—subrule 6.3(1) and Iowa Code chapter

155A and in executing the medical regimen as prescribed by the physician, the registered nurse did not exercise professional judgment in accordance with minimum standards of nursing practice as defined in these rules: 25.29(2)a, 655-6.2(5)e(152).

Monitoring Observation: A monitor observed staff administer medications to tenant's without error.

Review of weekly Medication/Medication Administration Record (MAR) audit sheets from 4-10-08 to 7-31-08, did not identify any medication errors that had occurred. According to an In-Service Tracking form dated 5-29-08, Certified Medication Aides (CMAs) attended a training regarding the medication administration policy and the five rights of medication administration.

- Regulatory Insufficiency: None noted.

E. 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]

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

Monitoring Observation: Tenant #5 had an ordered dated 7-23-08/7-24-08 (date difficult to determine) for PT and a UA. The order was not noted until 8-6-08 at 11:00 a.m., the day of the recertification revisit.

Tenant #8, an 84 year old, was admitted on 1-14-06 and has diagnoses of: Dementia, Depression, History of Right 12 Rib Fracture, Constipation, Pain and History of Low Hemoglobin. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. Progress notes of 7-25-08 through 8-1-08 indicated the tenant periodically refused evening medications and meals. Progress notes of 7-31-08 indicated the tenant is "moody" and less talkative and not walking well. Progress notes of 08-01-08 indicate the tenant's physician was notified in regard to the refusal of evening medications and meals. The program did not complete a nurse review despite a change in health status related to occasional refusals of evening medications, change in mood and not walking well.

Tenant #18's physician discontinued Lorazepam and started Haldol, 5 mg by mouth, every four hours, as needed, for agitation, according to a physician's order dated 7-23-08.. The nurse indicated in a statement, that on 7-26-08 at 10:00 p.m. she received an order for Lorazepam, 1 mg by mouth, every fours per a conversation with the tenant's doctor. The tenant's doctor stated he would write up the order and fax it to the program. According to progress notes dated 7-26-08 at 10:00 p.m., the doctor stated to give a Lorazepam immediately. The nurse put the order on the PRN medication sheet and the physician order sheet dated 7-26-08. The tenant received one dose of Lorazepam on 7-26-08 at 10:00 p.m. According to the nurse's statement, on 7-28-08 the nurse noted the order from the tenant's doctor was not received and wrote up the order and faxed it to the doctor, per the verbal order on 7-26-08. The order was noted 7-29-08 at 6:10 p.m.

- Regulatory Insufficiency: The program did not consistently ensure that health care professionals' orders for tenants receiving health care and or professional-directed care from the program are current. (25.30(2))

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

During the course of the August 2008 on-site revisit, a review of the Plan of Correction (POC) submitted in response to the recertification revisit and complaint investigation completed on 6-18-08, was completed. It was determined the program did not fully implement the Plan of Correction.

Monitoring Observation: The program's Plan of Correction indicated the program planned to make corrections in the following areas: Evaluation of Tenant and Service Plan. These corrections were not fully implemented.

- Regulatory Insufficiency: The program did not fully implement the Plan of Correction submitted. (25.8(3))

Dated this 30th day of September, 2008