IOWA DEPARTMENT OF

# INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

**DEMAND LETTER**
**CERTIFIED**

September 14, 2009

**Complaint Intake: #24460-C**
**#24717-C**

Kathy Dye, Divisional Operations Specialist
Bickford Cottage of Iowa City
3500 Lower West Branch Rd
Iowa City, IA 52245-4106

**RE: I. Final Complaint Investigation Report – #24460-C & #24717-C**
**II. Appeals/Hearings**
**III. Civil Penalty**
**IV. Conclusion**

Dear Ms. Dye:

**I. Final Complaint Investigation Report, Bickford Cottage, Iowa City, IA**

Enclosed is the **Final Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C, 321 Iowa Administrative Code chapter 25 (pertaining to assisted living programs), and 321 Iowa Administrative Code chapter 26 (pertaining to monitoring, civil penalties, and complaints). The report notes Regulatory Insufficiencies in the areas of: Evaluation of Tenants, Service Plans, Tenant Documents, Staffing and Other (not reporting substantial injury within 24 hours). Bickford Cottage of Iowa City ("Program") is being assessed a $500.00 civil penalty.

**II. Appeals/Hearings**

The Program may appeal the DIA decision in accordance with 321 Iowa Administrative Code rule 26.4, within 30 days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to 481 Iowa Administrative Code chapter 10. If the Program appeals, the civil penalty will be suspended, pending the appeal process.

**III. Civil Penalty**

If, within thirty (30) days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the penalty, the assessed penalty will be

reduced by thirty-five percent (35%) pursuant to Iowa Code section 231C.14. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send written notice to the Certification Coordinator and remit the penalty assessed by check or money order in the amount of three hundred twenty five dollars ($325.00) within 30 business days after the receipt of this demand letter.

**IV. Conclusion**

The Program is being assessed a $500.00 civil penalty. The Plan of Correction (POC) has been reviewed and 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 this letter and report, please contact your Certification Coordinator, Chris Nothaft, at 515-281-4116.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

**Assisted Living Program:**

**Complaint Intake #:** 24460-C
24717-C

Kathy Dye, Divisional Operations Specialist
Bickford Cottage of Iowa City
3500 Lower West Branch Rd
Iowa City, IA 52245-4106

**Date of Investigation:**

August 5 & 6, 2009

**Monitor(s):**

Hal Chase, RN BSN MPH
Stephanie Cummins, 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 complaint investigation on-site visit was conducted at Bickford Cottage of Iowa City on August 5 & 6, 2009. 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 definition 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): | 24 |
| Current number of tenants without cognitive disorder: | 11 |
| Total Population: | 35 |

***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 have been no substantiated Regulatory Insufficiencies this certification period.

**Complaint Investigation** – The complaint investigator(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)]

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

Monitoring Observation: Four tenant files were reviewed. Tenant #1, a 79 year old, was admitted on 4-3-06 and had diagnoses of: Dementia with Delirium, History of Diarrhea, Osteoarthritis, History of Pain and Elevated Temperature, History of Pulmonary Embolism and a History of Acute Sore Throat. A cognitive evaluation was completed on 7-28-09 and staged the tenant at a six on the Global Deterioration Scale (GDS). Nurse's notes dated 7-13-09, indicated the tenant was unable to bear weight and required two to three staff to transfer. Nurse's notes of the same date indicated the registered nurse (RN) reported to Physical Therapy (PT) there was a decline in the tenant's capabilities. A nurse review of the same date indicated the tenant's cares exceed what the program could provide. Nurse's notes of 7-14-09 indicated the tenant was very difficult to transfer with evening cares, verbal cues were unsuccessful and three staff were needed to transfer the tenant from a wheelchair to the toilet. On 7-16-09 the program requested a waiver related to occupancy and transfer criteria, as the tenant needed routine two staff assistance with ambulation, transfer and evacuation. Nurse's notes of 7-20-09 indicated the tenant would be evaluated for Hospice care and the tenant was unable to swallow pills whole. The tenant was admitted to Hospice the same day. Functional, cognitive and health evaluations were not completed when the program reported to PT they had seen a decline in the tenant's capabilities and when the tenant was evaluated and admitted to Hospice to determine what modifications to services were needed.

- Regulatory Insufficiency: The program did not consistently evaluate each tenant's functional, cognitive and health status as 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]

Complaint Allegation #24460-C: It was alleged a tenant had unmanageable incontinence and required three people for transfers.

Monitoring Observation: Four tenant files were reviewed. Tenant #1's nurse's notes of 7-14-09 indicated the tenant was very difficult to transfer with evening cares, verbal cues were unsuccessful and three staff were needed to transfer the tenant from a wheelchair to the toilet. On 7-16-09 the program requested a waiver from the rules for occupancy and transfer criteria as the tenant needed routine two staff assistance with ambulation, transfer and evacuation. Functional and health evaluations and the service plan of 7-28-09 indicated the tenant needed cueing and physical assistance with toileting. Staff #2 and Staff #3 did not identify the tenant as having unmanageable incontinence. A monitor observed staff toilet the tenant on two separate occasions and the tenant assisted in his/her toileting.

- Regulatory Insufficiency: None noted.

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

Complaint Allegation #24717-C: It was alleged the Do Not Resuscitate (DNR) Code Status was incorrect for Tenants #5 through #9 and Tenant # 11.

Monitoring Observation: A review of the program's policy on DNR orders indicated the tenant's code status would be located on the outside cover and inside the tenant's file record, on the Medication Administration Record (MAR), in the emergency handbook and posted in the tenant's apartment. Tenants #5 through #9 and #11s files and the program's tenant list/DNR/Cardio Pulmonary Resuscitation (CPR) Assist list, MAR and emergency handbook consistently identified the DNR status. Inspection of the tenants' apartments, revealed the DNR status was not designated correctly for Tenants #5 and #6. No designation of DNR status was found for Tenant's #7, #8, #9 and #11.

- Regulatory Insufficiency: The program did not consistently maintain a file for each tenant that contains advance directives as applicable. (25.27(1)i)

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

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

Monitoring Observation: Four tenant files were reviewed.

Tenant #1's nurse's notes dated 7-13-09 indicated the tenant was unable to bear weight and required two to three staff to transfer. Nurse's notes of the same date indicated the RN reported to PT there was a decline in the tenant's capabilities. A nurse review of the same date indicated tenant's cares exceed what the program could provide. Nurse's notes dated 7-14-09, indicated the tenant was very difficult to transfer with evening cares, verbal cues were unsuccessful and three staff were needed to transfer the tenant from a wheelchair to the toilet. On 7-16-09 the program requested a waiver from the rules related to occupancy and transfer criteria as the tenant needed routine two staff assistance with ambulation, transfer and evacuation. Nurse's notes dated 7-20-09, indicated the tenant would be evaluated for Hospice care and the tenant was unable to swallow pills whole. The tenant was admitted to Hospice the same day. The service plan was updated on 7-16-09, but the program noted on 7-14-09 there had been a decline over the previous two weeks. The tenant was admitted to Hospice on 7-20-09 but the service plan was not updated until 7-28-09.

Tenant #3, a 102 year old, was admitted on 6-16-07 and had diagnoses of: Congestive Heart Failure (CHF), Dementia, Diarrhea, Gastroesophageal Reflux Disease (GERD), GI (Gastrointestinal) Bleeding, Hypertension (HTN), Pain, Rash, Spinal Stenosis and Stasis Dermatitis. The tenant was staged at a six on the GDS, which indicated severe cognitive impairment. The tenant's service plan was updated on 6-25-09 and indicated the tenant was admitted to Hospice and a Home Health Aide (HHA) would visit one to three times per week. The service plan did not identify what services the home health aide would provide. According to a Hospice record, the HHA provided assistance with personal

cares. The service plan did not identify services provided by Hospice and the service plan was not specific to meet the needs of the tenant.

Tenant #4, a 92 year old, was admitted on 3-28-09 and diagnoses include: Atrial Fibrillation, Transient Ischemic Attack (TIA) and Basal Cell Carcinoma of the Face. The tenant was staged at a four on the GDS, which indicated moderate cognitive decline. The tenant's service plan was updated on 7-14-09 and indicated the tenant received Hospice services and services were yet to be determined. According to a Hospice record, the HHA provided personal cares one to two times per week. The service plan did not identify services provided by Hospice and the service plan was not specific to the meet the needs of the tenant.

- Regulatory Insufficiency: The program did not consistently update each tenant's service plan, as needed, when a tenant needs personal or health related care. (25.28 (3))

- Regulatory Insufficiency: The program did not consistently develop service plans that were individualized and indicate at a minimum; the tenant's identified needs and requests for assistance and expected outcomes; any services and care to be provided pursuant to the occupancy agreement with the tenant and the service provider(s) if other than the program; and for tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests. (25.28(4)a-d)

**E. 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 #24717-C: It was alleged there was a lack of nursing coverage in the building on 8-4-09.

Monitoring Observation: According to a staff schedule, on 8-4-09 Staff #1, an RN, worked from 6:45 a.m. to 3:15 p.m. The RN stated she was working on 8-4-09 and was on-call. She attended a mandatory nurse meeting and received work related calls while attending the meeting. Iowa Administrative Code, chapter 25, does not require an RN to be in the building 24 hours a day seven days a week; however, the nurse must be available and on-call as needed.

- Regulatory Insufficiency: None noted.

Complaint Allegation #24460-C: It was alleged a tenant was left unattended for 45 minutes on the toilet, fell and sustained a laceration to his/her finger from the pull cord which was wrapped around the handicapped assist bar. It was alleged the tenant had 17 sutures related to the injury.

Monitoring Observation: According to an incident report dated 6-6-09, Tenant #1 was assisted to the toilet by staff. While sitting, the tenant tried to get up using the hand rail, lost his/her balance and fell. The bathroom pull cord had been wrapped around the hand rail and while standing, the tenant's pinky finger was caught and it was lacerated during

the fall. The incident report indicted the fall occurred at 2:30 p.m. A review of the schedule indicated Staff #2, #3 and #4 were working the day shift on 6-6-09.

Staff #2 stated she asked Staff #4 if she needed assistance toileting Tenant #1 and Staff #4 told her no and it was fine for her to go home. Staff #2 stated her shift ended at 2:00 p.m. and she left. Staff #2 arrived back at the program at 4:00 p.m. and she was told that Tenant #1 was in the emergency room (ER).

Staff #3 stated she worked day shift on 6-6-09 and she worked with Staff #2 and #4. Staff #3 stated at 1:45 p.m. on 6-6-09 she asked Staff #2 and #4 who else needed to be toileted and they told her Tenant #1 was on the toilet. Staff #3 stated Staff #2 left at 1:55 p.m. At 2:30 p.m. Staff #3 was in the nurse's station and Staff #4 sat down beside her. Staff #3 asked Staff #4 if she was finished and Staff #4 told her that she had to finish initialing the Medication Administration Records (MARs). Staff #3 stated Staff #4 looked up at the clock and replied "Oh my God I forgot about..."! Staff #3 stated she and Staff #4 went together to Tenant #1's apartment. The tenant was on the floor, against the wall with briefs and underwear between his/her knees and ankles. There were blood drops on the bathroom floor, on the tenant's thighs and on the call cord. The call cord was wrapped tightly around the grab bar, according to Staff #3. Staff #3 stated Staff #4 replied "Oh I'm so sorry ..., I didn't mean to. I'm so sorry." Staff #3 helped Tenant #1 get his/her briefs and pants up and observed creases on the tenant's buttocks and back of the thighs. Staff #3 stated Staff #4 called the ambulance. The tenant's hand was wrapped in a towel and he/she was brought to the lobby. Staff #3 clocked out at 3:40 p.m. Staff #3 reported the incident to Administrative staff on 6-8-09.

Staff #4 was interviewed and stated she worked day shift on 6-6-09. She stated at 1:45 p.m. she finished rounds with Staff #2. Tenant #1 needed a two person assist to get onto the toilet and she and Staff #2 put the tenant on the toilet. Staff #4 stated they let him/her go to the bathroom and gave him/her privacy. Staff #4 stated Staff #2 left at 2:00 p.m. Staff #4 stated she left the apartment and was multitasking. Staff #4 stated she went back to the tenant's apartment by herself, found the tenant on the floor and then called Staff #3 for assistance. Staff #4 stated she found the tenant on the floor with his/her back against the wall and stated she did not witness the fall. Staff #4 provided a written statement dated 6-8-09. According to the statement, at 2:00 p.m. Staff #2 and #4 transferred the tenant to the toilet. After 10 minutes Staff #2 had to leave and asked Staff #4 if they should leave the tenant on the toilet. Staff #4 stated she told Staff #2 to go home and she would take care of the tenant. Staff #4 stated she checked on the tenant at 2:15 p.m. and he/she was still sitting on the toilet and said he/she was not finished. Staff #4 left to do other work and forgot about the tenant until 2:45 p.m. According to Staff #4's written statement, she and another co-worker ran to check on the tenant and found the tenant on the floor in the bathroom. Staff #4 stated the tenant had a laceration to the right pinky finger. She immediately called the nurse, family and ambulance. Staff #4 accompanied the tenant to the ER and stayed with the tenant until family members arrived.

According to a fax to the tenant's doctor the tenant was sent to the ER after a fall related to a deep laceration to the right hand fifth digit. The tenant received 14 stitches and would need to return to the ER or go to the tenant's doctor to have them removed in 14 days due to the extent of the laceration/shearing type injury.

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

**F. 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 #24717-C: It was alleged a utility closet was unlocked.

Monitoring Observation: The monitors observed the utility closet in the northeast hall was unlocked; however, there were no chemicals or unsafe materials located in the closet.

- Regulatory Insufficiency: None noted.

Complaint Allegation #24460-C: It was alleged mold was in the air conditioning vents in several tenants' apartments, standing water in a tenant's shower and mold was painted over in a tenant's apartment.

Monitoring Observation: The Maintenance Log from 4-16-09 to the time of the on-site visit was reviewed. On 4-27-09, the log indicated "mold/musty smell need fans." This was the only documented entry related to mold in the maintenance log. Staff #5, maintenance staff, was interviewed and stated there were no issues with mold in the building; however, the air conditioning vents may have dirt in them but not mold. Staff #5 stated none of the tenants have complained about mold. He stated in one of the tenant's apartments a window was leaking and it was patched and he was waiting to make sure the leak was fixed before the final coat was applied. He stated none of the tenants complained about the windows. Staff #5 stated the showers did not drain like a bathtub and were not sloped as much and the water had to be assisted down the drain. He had not observed mold related to the showers and water. Staff #5 had not found mold under the anti-slip pads and none of the tenants have complained about standing water or mold in the showers. A visual inspection by a monitor was conducted. Tenant #5, #12, and #13's apartments were inspected and no mold and mildew was found in the ventilation and filtration of the air conditioning units. Tenants #5, #12 and #13 stated there were no problems with mold or mildew in their apartments. Tenant #16 was not available for an interview. Tenant #16's apartment was inspected and small black spots were noted in the vent but not in the filtration of the air conditioning unit. Tenant #15's shower was inspected and drained appropriately. Tenant #14's apartment was inspected regarding the window closure and the window did not lock. The program was notified of this issue at the time of the on-site visit.

- Regulatory Insufficiency: None noted.

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

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

Monitoring Observation: Tenant #1 was found on the floor on 6-6-09 and sustained a laceration to the right hand, fifth digit. The tenant was taken to the ER and the laceration required 14 stitches and the tenant would need to return to the ER or go to the tenant's

doctor to have them removed in 14 days, due to the extent of the laceration/shearing type injury. The fall with substantial injury was not reported to DIA.

Tenant #2, an 89 year old was admitted on 6-7-09 and has diagnoses of: Dementia and Hyperlipidemia. Nurse's notes dated 6-30-09 indicated the tenant told staff he/she had fallen in the bathroom and complained of "hurt ribs." The RN evaluated the tenant and noted the tenant had complained of pain with ambulation and she would monitor the tenant. Nurse's notes dated 7-1-09 indicated staff found the tenant lying on the floor with a complaint of pain and noted an abrasion and ecchymosis to the left hip. The tenant could not straighten the left leg and was complaining of lower left back pain. An ambulance was called and the tenant was transported to a local ER. Nurse's notes dated later the same day indicated the program was notified the tenant had a fractured left hip. Nurse's notes dated 8-6-09 indicated the tenant transferred from the hospital to a local skilled nursing facility. The fall with substantial injury was not reported to the Department.

- Regulatory Insufficiency: The program did not notify the Department of Inspections and Appeals within twenty-four hours, by the most expeditious means available, of any accident causing substantial injury or death, and any fire or natural or other disaster occurring at or near the assisted living program. (231C.12)

Dated this 14th day of September, 2009.