IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

DEMAND LETTER
CERTIFIED

January 14, 2010

Incident Intake #: 25903-I

Ms. Mary Keen, Director
Bickford Cottage
101 New Castle Road
Marshalltown, IA 50158

RE: I. Final Incident Investigation Report – Bickford Cottage, Marshalltown, IA
II. Appeals/Hearings
III. Civil Penalty
IV. Conclusion

Dear Ms. Keen:

Enclosed is the **Final Incident 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: Other (non-notification of incident resulting in significant injury). Bickford Cottage Assisted Living ("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) submitted on January 4, 2010, has been reviewed and will constitute the final POC related to the on-site visit of December 15, 2009.

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, Tamara Halvorson, at 515-281-5721.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Incident Investigation Monitoring Evaluation Report

Assisted Living Program:

Incident Intake #: 25903-I

Mary Keen, Director
Bickford Cottage
101 New Castle Road
Marshalltown, IA 50158

Date of Monitoring Visit:

December 15, 2009

Monitor:

Joyce Kix, 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 25.8(3)]. 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 Recertification Monitoring Evaluation 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 this chapter 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 specialized care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site incident investigation was conducted at Bickford Cottage of Marshalltown on December 15, 2009. 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:	28
Current number of tenants with cognitive disorder:	4
Total Population of GPP:	32

***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 was a substantiated Regulatory Insufficiency in the area of Other (tenant rights) during this certification period.

Incident Investigation – The monitor made the observations detailed in the following areas.

A. 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]

Incident Allegation: The program reported a tenant fell in his/her apartment on 10-14-09. He/she was evaluated by portable x-ray on 10-19-09 and was diagnosed with a right fractured hip.

- Monitoring Observation: Tenant #1, a 97 year old, admitted on 2-20-09 had diagnoses including: Alzheimer's Disease, Hypertension, Congestive Heart Failure, Chronic Kidney Disease, Anemia, Glaucoma and Macular Degeneration. The Global Deterioration Scale completed on 10-27-09 scored the tenant at seven indicating very severe cognitive decline. The nursing assessment completed 10-5-09 indicated the tenant required stand-by-assist at all times for ambulation. The Progress Notes dated 10-14-09 documented the tenant was found lying on the floor and complained of right leg pain and could not bear weight on the right leg. The tenant was treated with Acetaminophen with some relief; however, on 10-15-09 the tenant still could not bear weight on the right leg and was moaning and grabbing at upper leg area. The program notified the physician and received an order for portable x-ray. The portable x-ray was unable to complete the x-ray on 10-15-09 or 10-16-09. Progress Note of 10-16-09 indicated the tenant's family wanted to wait for a portable x-ray and elected not to take the tenant by ambulance to the emergency room or clinic. Diagnostic Imaging Report dated 10-19-09 indicated the diagnosis of right hip fracture. Progress notes of 10-20-09 (late entry for 10-19-09) indicated the physician felt the tenant could not tolerate surgery to repair the fracture and recommended hospice care. The tenant began hospice care on 10-21-09. During interview on 12-15-09 at 2:00 pm, the Director of Nursing stated that the Interim Director began discussions with the Bickford Divisional Nurse regarding proceeding with a request for waiver on 10-21-09; however, she did not begin the paperwork. The tenant died on 10-27-09.

- Regulatory Insufficiency: None noted.

B. 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: The clinical record of Tenant #1 indicated the tenant was found on the floor on 10-14-09 at 2:15 pm and complained of right leg pain and could not bear weight on the right leg. The tenant was treated with Acetaminophen with some relief; however, on 10-15-09 the tenant still could not bear weight on the right leg and was moaning and grabbing at upper leg area. The program notified the physician and received an order for portable x-ray. The portable x-ray was unable to complete the x-ray on 10-15-09 or 10-16-09. Progress Note of 10-16-09 indicated the tenant's family wanted to wait for portable x-ray and elected not to take the tenant by ambulance to emergency room or clinic. Diagnostic Imaging Report dated 10-19-09 indicated the diagnosis of right hip fracture. Progress notes of 10-20-09 (late entry for 10-19-09) completed by the Director of Nursing indicated she was made aware of the tenant's fracture by phone call from staff at the program. During interview on 12-

15-09 at 1:30 pm the Director of Nursing reported that she had called the Interim Administrator on 10-19-09 and informed her of the tenant's injury. The Director said that it was Bickford's policy that the Administrator notify the Department of Inspections and Appeals (DIA). Documentation of Online Incident Reporting indicated the Administrator did not notify DIA until 12-21-09 at 9:46 pm.

- Regulatory Insufficiency: The program did not notify the Department of Inspections and Appeals within 24 hours, by the most expeditious means available of any accident causing substantial injury or death, and any substantial fire or natural or other disaster occurring at or near an assisted living program. (231 C.12)

Dated this 14th day of January 2010.