IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

DEMAND LETTER
CERTIFIED

Incident: #26995-I
26668-I

March 17, 2010

Heidi Fristo, Administrator
Bickford Cottage Assisted Living
5050 Hawthorne Drive
West Des Moines, IA. 50265-5353

RE: I. Final Incident Investigation Report, Bickford Cottage Assisted Living, West Des Moines, IA
II. Appeals/Hearings
III. Civil Penalty
IV. Conclusion

Dear Ms. Fristo:

I. Final Incident Investigation Report, Bickford Cottage Assisted Living, West Des Moines, IA

Enclosed is the **Final Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C, 481 Iowa Administrative Code (IAC) chapters 67 and 69 (pertaining to assisted living programs), and 481 IAC Rule 67.12(3) (pertaining to monitoring, civil penalties, and complaints). The report notes Regulatory Insufficiency in the area of: Life Safety. Bickford Cottage ("Program") is being assessed a $1,000.00 civil penalty.

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

II. Appeals/Hearings

The Program may appeal the DIA decision in accordance with 481 IAC rule 67.13, within 30 days of notice, by submitting a request for appeal to DIA. A contested case hearing will be

held pursuant to 481 IA C chapter 10. If the Program appeals, the civil penalty will be suspended, pending 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 IAC rule 67.12(3)d. 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 six hundred fifty dollars ($650.00) within 30 business days after the receipt of this demand letter.

IV. Conclusion

The Program is being assessed a $1,000.00 civil penalty. 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 regarding this letter and report, please contact your Certification Coordinator, Connie Schaffer, at 515-281-5003.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Heidi Fristo, Administrator
Bickford Cottage Assisted Living
5050 Hawthorne Drive
West Des Moines, IA. 50265-5353

Incident Intake: #26995-I
26668-I

Date of Incident Investigation:

February 9, 2010

Monitor(s):

Hal L. Chase, RN BSN MPH

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. IAC r. 481-67.10(5). 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 an Incident 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 481 IAC - chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Bickford Cottage Assisted Living on February 9, 2010. 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:	33
Current number of tenants with cognitive disorder:	0
Total Population of GPP:	33

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	7

Total Census of ALP: 40

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

Tenant/Family Satisfaction Results – Not applicable.

Program History – The program has had substantiated Regulatory Insufficiencies in the areas of: Evaluation of Tenant, Service Plan, Medications, Nurse Review, Staffing and Structural Requirements during this recertification period.

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

A. Service Plan

Incident Allegation #26995-I: The program reported Tenant #1 fell while being assisted to the bathroom and fractured his/her left hip.

- Monitoring Observation: Tenant #1, a 78 year old, was admitted on 7-2-2008 and had diagnoses of: Dementia, Peptic Ulcer Disease, Lymphoma, History of Status Post Lymphnode removal of the Left Thigh. The tenant was staged at six on the GDS, which indicated severe cognitive decline. An incident report of 1-7-10 indicated Staff #1 had seen the tenant fall after asking the tenant to sit on the toilet. She heard the tenant's feet move and then heard a slight yell. Staff #1 indicated she went to help the tenant but didn't make it in time to prevent the tenant from falling. Progress notes of 1-7-10 indicated the tenant complained of pain during ambulation. A portable x-ray was taken and the tenant was taken by ambulance to a local emergency room for evaluation and later admitted. Nurse's notes of 1-12-10 indicated the tenant returned to the program. Hospital discharge orders of 1-12-10 indicated the tenant was diagnosed with a Left Hip Hemiarthroplasty.

  The service plan of 11-4-10, which was used during the time of the incident, indicated the tenant was independent with ambulation and requested staff to remind him/her to use the toilet, to show the tenant where the toilet was, to provide peri-care as needed and assist with undergarments when incontinent.

  A service plan was updated on 1-12-10, which was supported by functional, cognitive and health evaluations of the same date and reflected the hospital discharge instructions for physical therapy and additional personal and health related cares.

- Regulatory Insufficiency: None noted.

B. Life safety

Incident Allegation # 26668-I: The program reported Tenant #2 had stepped out into the courtyard, took a few steps and fell, fracturing his/her left humerus.

Monitoring Observation: Tenant #2, a 77 year old, was admitted on 3-31-09 and has a diagnosis of Dementia. The tenant was staged at six on the GDS, which indicated severe cognitive decline. An incident report of 12-14-09 at 1:30 pm. indicated the tenant was found lying on the sidewalk in the dementia unit courtyard. The tenant had complained of arm pain. Local emergency 911 was called and the tenant was transported to a local hospital emergency room for evaluation. Progress notes of 12-14-09 indicated the tenant returned to the program later that day.

On 12-15-09, the program reported to the Department that prior to the incident the tenant wanted to go outside several times, but staff had been able to redirect the tenant away from the courtyard door. Staff #4, who was present at the time and assisting another tenant, saw the tenant step through the door leading into the courtyard, take a few steps and fall, landing on his/her left arm.

In a prepared statement dated 2-9-10, the Administrator indicated Staff #4 left the dining room to go to the laundry room, returned to the dining room and found the tenant lying on the ground. The universal transmitter (alarm) connected to the courtyard door from the dining room was on a timer and was turned off between 12:00 p.m. and 2:00 p.m. Staff #3 stated the alarm was turned off during the day, was on during the night, but is now on 24-hours a day. Staff #4 stated the alarm was not on the day of the incident.

- Regulatory Insufficiency: An operating alarm system shall be connected to each exit door in a dementia-specific program. A program serving a person(s) with cognitive disorder or dementia, whether in a general or dementia-specific setting, shall have: written procedures regarding alarm systems and appropriate staff response when a tenant's service plan indicates a risk of elopement or a tenant exhibits wandering behavior. (IAC r.481-69.32(2)(a))

Dated this 17th day of March, 2010.