IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

**DEMAND LETTER**
**CERTIFIED**
**Incident Intake #: 29995-I**
**Complaint Intake #: 29997-C**
**30014-C**

September 23, 2010

Ms. Patricia McNichol, Administrator
Bickford Cottage Assisted Living
3500 Lower West Branch Road
Iowa City, IA 52240

**RE: I. Final Incident & Complaint Investigation Report**
**II. Civil Penalty**
**III. Appeals/Hearings**
**IV. Conclusion**

Dear Ms. McNichol:

**I. Final Incident & Complaint Investigation Report – Bickford Cottage Assisted Living, Iowa City, IA**

Enclosed is the **Final Incident & Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69. The Report notes Regulatory Insufficiencies in the area(s) of: Medications and Staffing. **Bickford Cottage Assisted Living** ("Program") is being assessed a $500 civil penalty.

**II. Civil Penalty**

If, within 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 civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—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 a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order

in the amount of three hundred twenty five dollars ($325) within 30 business days after the receipt of this demand letter.

**III. Appeals/Hearings**

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

**IV. Conclusion**

The Program is being assessed a $500 civil penalty. The Plan of Correction (POC) submitted on September 17, 2010, has been reviewed and will constitute the final POC related to the on-site visit of August 12, 2010.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal 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 enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039.

Sincerely,

*Ann Martin*

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

**Assisted Living Program:**

Patricia McNichol, Administrator
Bickford Cottage Assisted Living
3500 Lower W. Branch Road
Iowa City, IA 52240

**Incident Intake:** #29995-I
**Complaint Intake:** #29997-C
**Complaint Intake:** #30014-C

**Date of Incident Investigation:**

August 12, 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 August 12, 2010. 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 fewer than 55 tenants and has 5 or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS) : | 7 |
| Current number of tenants without cognitive disorder: | 25 |
| Total Population: | 32 |

***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** – There have been substantiated Regulatory Insufficiencies this certification period in the areas of: Evaluation of Tenants, Tenant Documents, Service Plans, Medications, Staffing, Nurse Review, Dementia – Specific Education, Record Checks and Other (not notifying DIA within 24 hours of an incident resulting in serious injury or death).

The February 16, 17 and 18, 2010 Incident and Complaint Investigation resulted in a civil penalty of $1,000.00 and Regulatory Insufficiencies in the areas of: Medications, Staffing, Dementia – Specific Education and Record Checks.

The October 6 and 7, 2009 Incident Investigation resulted in a civil penalty of $1,000.00 and a Regulatory Insufficiency in the area of Other (not notifying DIA within 24 hours of an incident resulting in serious injury or death).

The August 5 and 6, 2009 Complaint Investigation resulted in a civil penalty of $500.00 and Regulatory Insufficiencies in the areas of: Evaluation of Tenants, Tenant Documents, Service Plans, Staffing and Other (not notifying DIA within 24 hours of an incident resulting in serious injury or death).

The May 12, 13 & 17, 2010 Complaint Investigation resulted in substantiated Regulatory Insufficiencies in the areas of Nurse Review and Staffing.

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

## A. Service Plan

Complaint Allegation #30014-C: It is alleged the program lost two of Tenant #1's top plates and the program did not notify the tenant's family. The tenant continuously took them out because staff did not complete oral care as indicated in the tenant's service plan. One staff member reported to the tenant's family in December 2009 she didn't know the tenant had a bottom plate as no one told her. It is alleged the tenant had dental caries due to poor oral hygiene.

- Monitoring Observation: Tenant #1 no longer resides at the program. The tenant, a 90 year old, was admitted on 2-25-06 and had diagnoses of: Actinic Keratosis, Anxiety, Congestive Heart Failure, Constipation, Dementia, History of Diarrhea, Eczema, Hemorrhoids, Hypertension, Hyperlipidemia and a History of Pain. A Global Deterioration Scale (GDS) was completed on 5-21-10 and staged the tenant at six which indicated severe cognitive decline.

  A service plan of 5-21-10 indicated staff were to remove the tenant's dentures and soak them every night. The tenant's family member provided a special brush to brush the tenant's gums after removing the dentures. Staff were to notify the tenant's family member when the tenant is running out of denture tablets. Oral care is to be given after each meal and staff were ensure no food remained pocketed in the tenant's cheeks as this could cause sores in the mouth or choking. The tenant would remove his/her teeth at the table from time to time and had a history of loosing his/her teeth. Family requested the tenant's teeth be stored in the tenant's room until meal time. Staff were to put the tenant's teeth in before coming to the table. When the meal was finished or if the tenant still would not keep his/her teeth in staff were to take the tenant's teeth and put them back in their container for storage.

  Staff #1 and #2 stated they reviewed the tenant's service plan which directed staff to brush the tenant's upper dentures and partial lower dentures and brush the tenant's gums and lower teeth after each meal. Staff #1 stated the tenant would often take his/her dentures out and place them in different places throughout the apartment, hiding them in tissue. Staff #2 stated the tenant would take out his/her dentures and place them in tissue and hide them in the apartment. Staff searched the tenant's apartment, common areas and other tenants' apartments, but did not find them. A second pair were also lost despite staffs attempts to keep track of them. The tenant's dentist was contacted and stated the tenant had dental caries but he could not determine if the caries were caused from poor oral care.

- Regulatory Insufficiency: None noted.

## B. Medications

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

- Monitoring Observation: Tenant #3's Medication Administration Records (MARs) indicated Lorazepam 0.25mg tablets was charted as given at 8:00 a.m. Individual tenant's record indicated the Administrator, who is a RN, recorded Lorazepam

0.25mg was removed from the bubble pack at 8:00 a.m. The Administrator stated she charted the medication was given at 8:00 a.m. but wasn't given until 9:30 a.m.

Tenant #4's MARs indicated 8:00 a.m. medications were not administered to the tenant. The tenant was to be supervised when tenant self administered his/her medications.

Tenant #5's MARs of 8-12-10 indicated the following morning medications were charted as given: Aspirin – 81mg tablet at 8:00 a.m., Cerovite Silver – one tablet at 8:00 a.m., Lasix – 40mg tablet at 8:00 a.m., Lipitor – 10mg tablet at 8:00 a.m. and Metoprolol ER – 50mg tablet at 8:00 a.m. A review of the medication bubble packs confirmed morning medication for 8-12-10 had been administered in addition to the same morning medications for the following day, 8-13-10. The Administrator stated the tenant's morning medications were given twice but only charted as given once. A review of the tenant's MARs did not indicate the tenant was given the same medications twice. The Administrator stated she had contacted the tenant's physician, informing him/her of the error, but had not documented she had called the physician.

- Regulatory Insufficiency: When medications are administered traditionally by the program the administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6)(a))

**C. Staffing**

Incident Allegation #29995-I The program reported Tenant #2 was wearing street clothes when he/she sat outside. The tenant was sitting with another tenant on the front porch. The tenant wandered around the building but did not display exit seeking behavior. The tenant ambulated without assistance and wore a wanderguard watch. The wanderguard should have alarmed, but the program's system did not indicate the signal was picked up when the tenant exited the program. The alarm system is checked weekly and the program computer system typically alerts staff when something has a low battery or if a tenant is missing.

Complaint Allegation #30014-C & #29997-C: It is alleged Tenant #2 was outside the program and was left unattended. It is alleged the program's call system had been down for awhile. Nothing alarmed when the tenant went outside.

- Monitoring Observation: Tenant #2, a 93 year old, was admitted on 1-31-09 and had diagnoses of: Arial Fibrillation, Benign Prostatic Hypertrophy, Coronary Vascular Disease, Congestive Heart Failure, Eczema, Hypertension, Macular Degeneration, History of Pain, History of Cerebral Vascular Accident and Vascular Dementia. A GDS was completed on 2-25-10 and staged the tenant at four, which indicated moderate cognitive decline.

  An incident report of 8-6-10 indicated Staff #1 reported she saw the tenant sitting in a rocking chair on the front porch, outside the program when she left at 2:00 p.m. and was still there when she returned at 3:00 p.m. The tenant reported he/she went

outside the program with "some other people." Service plan of 2-25-10 indicated the tenant staff was to monitor the tenant, as the tenant was and elopement risk. The tenant was to have a wanderguard watch on at all times.

The program's regional RN indicated the wanderguard watch system is a separate system from the key pad used to unlock the exit doors. The tenant indicated he/she walked out with other visitors. Program records indicated the wanderguard system was checked weekly beginning 5-24-10 through 8-2-10 and indicated the system was working without any problems.

Staff #1 stated she was not present on the day the tenant eloped from the program. She stated the tenant had not attempted to elope from the program. The tenant was independent with ambulation and wore a wanderguard watch and the system had been working on a regular basis without any down time.

Staff #2 stated she was present on the day the tenant eloped, but didn't remember if the alarm went off when the tenant left the program. The tenant was found outside, sitting in a rocking chair. The tenant wore a wanderguard watch and the watch was working on the day of the elopement. When the tenant came back in she heard the home free system go off and staff's pager alarmed.

The regional RN indicated they suspected visitors leaving the program blocked the eye of the system and did not detect the tenant's watch.

Program documentation indicated the "home free" watch was worn by the tenant, identified the tenant, and monitored the tenant's location and alarm when the tenant would come close to an exit door of the program. Computer records indicated the "home free" system recorded 12 events on 8-6-10, recorded the tenant coming into the program at 3:03 p.m. from the front porch, but did not record the tenant leaving the program. Computer records indicated the "home free" system recorded 4 events between 7-26-10 and 8-1-10 and 58 events between 8-2-10 and 8-8-10. Program records indicated the "home free" system was checked weekly beginning 5-24-10 through 8-2-10 and indicated the system was working without any problems.

- Regulatory Insufficiency: Each tenant shall have access to a 24-hour personal emergency response system that automatically identifies the tenant in distress and can be activated with one touch. (IAC r.481-69.29(1))

**D. Structural requirements**

Complaint Allegation #30014-C: It was alleged the program hasn't been cleaned properly in a while. Tenant #1's room was dirty on the days the housekeeper wasn't at the program.

- Monitoring Observation: A visual inspection of Tenant #1's apartment was not completed, as the tenant no longer resided at the program. The tenant's service plan indicated the program provided weekly housekeeping services. Three tenants were interviewed. Tenant #6 stated he/she was satisfied with the weekly housekeeping services. The tenant stated the building and grounds were clean and neat. Tenant #7 stated he/she was satisfied with the weekly housekeeping services. There were new

housekeepers because the full time housekeeper no longer works for the program. The tenant stated the building and grounds were clean and neat. Tenant #8 stated he/she was upset the full-time housekeeper no longer worked for the program, but stated he/she was satisfied with the weekly housekeeping services. The tenant stated the building and grounds were well cared for.

Staff #1 stated tenants received weekly housekeeping services. Housekeepers from another program come weekly and help with housekeeping. Tenants have complained Staff #3, the past housekeeper, hasn't cleaned their apartments in the past three weeks. Staff #2 stated tenants usually receive weekly housekeeping services. Since the housekeeper has left tenants are not receiving housekeeping services on a weekly basis.

The Administrator stated two housekeepers from another program and an additional, as needed housekeeper, provided weekly housekeeping services. Staff had been instructed to clean tenant bathrooms when needed. A review of housekeeping staff schedules for July and August 2010 indicated a housekeeper was scheduled weekly at the program.

- Regulatory Insufficiency: None noted.

Dated this 22nd day of September, 2010.