IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

**DEMAND LETTER**
**CERTIFIED**
**Incident Intake #: 28141-I**

October 25, 2010

Ms. Cindy Egdorf, Administrator
Bickford Cottage Assisted Living
1530 20th Avenue North
Fort Dodge, IA 50501

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

Dear Ms. Egdorf:

**I. Final Incident Investigation Report – Bickford Cottage Assisted Living, Fort Dodge, IA**

Enclosed is the **Final Incident 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 a Regulatory Insufficiency in the area(s) of: Criteria for Exclusion of Tenant. **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 **Tamara Halvorson** 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 October 8, 2010, has been reviewed and will constitute the final POC related to the on-site visit of August 3 & 14, 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 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 Report

**Assisted Living Program:** **Incident Intake #:** 28141-I

Ms. Cindy Egdorf, Administrator
Bickford Cottage Assisted Living
1530 20th Avenue North
Fort Dodge, IA 50501

**Date of Incident Investigation:**

August 3 & 14, 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 3 and 14, 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 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS: | 8 |
| Current number of tenants without cognitive disorder: | 28 |
| Total Population: | 36 |

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

**Program History** – There were substantiated Regulatory Insufficiencies found in the areas of Medication and Staffing during this certification period.

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

## A. Criteria for Exclusion of Tenant

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

- Monitoring Observation: Tenant #1, an 88 year old, was admitted on 7-31-07 and had diagnoses of: History of Cerebral Infarct, Hypertension (HTN), Osteoarthritis, Weakness, Urinary Incontinence and Memory Loss. On 5-6-10 the tenant was staged at six on the Global Deterioration Scale, which indicated severe cognitive decline. The service plan of 5-6-10 indicated staff was to use a gait belt for all transfers and to instruct the tenant to place feet in proper position and to hold onto mobility bar or walker to aide in transfer. Staff was to cue throughout the entire transfer, use a pivot disc for transfers as needed and an extensive assist of one with transfer and two intermittently with transfers in late afternoon and evening. Transfer assist with two staff with toileting for safety measures only. The tenant had a bed mobility bar to aide in bed mobility and transfers. A nurse review was completed on 5-6-10 and 7-14-10 and indicated the tenant was oriented to person only, able to verbalize needs, but was confused and forgetful. A nurse review of 7-14-10 indicated the tenant was oriented to person only and was able to verbalize needs most of the time.

  Staff #1, #2, #3 and #4 were interviewed and stated the tenant was a routine two person transfer and unable to use an assistive device or transfer independently. Staff #1 stated the tenant is a routine two person transfer as it was not safe to transfer the tenant with one staff. The tenant does not bear weight and does not consistently participate in the transfer. A pivot disc is used but the tenant is not able to use it as the tenant is demented and unable to understand how to use the device. Staff #2 stated the tenant is very heavy, doesn't bear weight, can't use the pivot disc and can't stand. The tenant is not safe to transfer with one staff. Staff #3 stated the tenant is dead weight, will not bear weight and will not stand. The tenant can't feel his/her legs anymore. Staff #4 stated the tenant is a two person transfer "all of the time." The tenant can't bear weight and doesn't understand how to use a pivot disc.

  The Administrator and registered nurse (RN) stated the tenant is not a routine two person transfer. Both indicated they were puzzled as to why staff hasn't told them the tenant was a routine two person transfer. The RN indicated the last evaluation of 5-6-10 indicated the tenant was one person assist with transfer. The RN indicated some of the staff wasn't comfortable transferring the tenant by themselves.

  A monitor observed two separate times when staff transferred the tenant. The first observation noted two staff to transfer the tenant from a wheelchair to the toilet, a transfer from the toilet to wheelchair and from the wheelchair to bed. The second observation noted two staff to transfer the tenant from the bed to a wheelchair. It was observed that the tenant did not participate in the transfers and did not bear weight.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who requires routine, two-person assistance with standing, transfer or evacuation. (IAC r. 481-69.23(1)(b))

**B. Other**

Incident Allegation: The program reported staff found Tenant #2 sitting on the floor next to his/her bed shortly before lunch. The RN completed an assessment and determined the tenant would not straighten his/her right leg. The tenant was transferred to an emergency room and was found to have a right femoral neck fracture.

- Monitoring Observation: Tenant #2 passed away on 5-7-10. Tenant #2, an 83 year old, was admitted on 10-5-08 and had diagnoses of: History of Left Femoral Fracture, Status Post Surgery of L3, L4 and L5 Compression Fracture, HTN, Osteoporosis, Pneumonia, Megaloblastic, Hypomagnesaemia, Hypoalbuminemia, Hypocalcaemia, Alzheimer's Dementia, Deep Vein Thrombosis of the Left Leg and Edema. On 1-7-10 the tenant was staged at six on the Global Deterioration Scale, which indicated severe cognitive decline. Progress notes of 1-7-10 through 4-1-10 indicated the tenant had a history of being found on the floor next to the bed.

  An incident report of 4-1-10 indicated staff found the tenant on the floor next to the bed. The tenant complained of pain to the right hip area and was unable to straighten the right leg. The tenant was transferred to an emergency room. The tenant's bed alarm was not sounding at the time of the fall. A service plan of 1-7-10 indicated a bed and chair alarm were to be used for added safety.

  Progress notes of 4-8-10 indicated the tenant returned to the program. Functional, cognitive and health evaluations were completed on 4-9-10 and a service plan was updated on the same day. Service plan of 4-9-10 indicated staff was to use a gait belt for all transfers and ambulation. A bed and chair alarm was used for the tenant's safety. Progress notes of 4-20-10 indicated the RN completed a nurse review which indicated the tenant was oriented to self and was able to verbalize needs. Progress notes of 4-21-10 indicated the tenant was seen by his/her physician and new medications were ordered. Progress notes of 5-7-10 indicated staff found the tenant unresponsive and the tenant passed away.

  The bed and chair pad alarm was part of the monitoring system called "The Home Free System" which monitored tenants for emergency calls for assistance and included the use of a chair and bed pad alarm. The pad alarm was a small, battery operated device, connected to a chair or bed monitoring mat. The pad alarm was used to notify staff when the tenant gets out the bed. The bed pad alarm was positioned at the bedside. The monitoring station computer retrieved the transmission via a wireless monitoring base unit which displayed a signal and alerted staff by pager when the alarm was activated. The Administrator stated the Home Free System was checked weekly. Records indicated the system was checked weekly from 1-5-10 through 8-16-10. Staff attended a yearly in-service on the use of the system and were trained to check the monitor when a device was not working properly and needed to be reset. Records indicated the program conducted an in-service on the Home Free System on 1-27-10, 3-25-09 and 3-28-08.

  Staff #1 stated she had annual in-services on the use of the watches and chair and bed alarm systems. She stated the manual to the system is located next to the phone in the office. When an alarm system is put into service the expiration date is put on the pad so staff will know when to replace it. Tenant #2 had a history of falls and sliding out

of the chair. She stated the tenant fell on 3-31-10 and she remembered the alarm sounding but did not recall if her pager sounded. She stated she wasn't present on 4-1-10, the day of the incident, but stated over the last few months there were times when the system did not activate the paging system. The pager she was using during this monitoring visit did not have an antenna. She stated she had spoken to the Home Free System office and they explained if the antenna was off, the pager will not always pick up the system's alarm signal.

Staff #2 stated Tenant #2 had fallen on 4-1-10 and the bed alarm pad wasn't working. Staff #3 stated the tenant was in bed and the bed alarm activated. Staff found the tenant on the floor. The tenant indicated he/she was trying to get something. She called the RN, assessed the tenant and the tenant was transported to an emergency room. Staff #4 stated she wasn't present on the day of the incident but stated the pad alarm worked when she used it. Staff #5 stated staff was given in-services two to three times a year or when there are problems. She stated she wasn't working on 4-1-10, when the tenant fell, but stated pagers for the Home Free System were to have an antenna. She stated staff put a lot of wear and tear on the pagers and the antenna breaks off, resulting in the pagers not always get the message an alarm is going off. Staff #5 stated she had noticed more problems with the pagers not going off or a delay on the fall device units.

Staff #6 stated she recently attended an in-service on the Home Free System and in-services have been held as needed or when changes were needed. She stated there could be a problem with the pager if the antenna is broken off or if the pad alarm is not working or missing a piece. She stated there had been some issues with the pagers not working in the last few months.

Staff #7 stated staff had an annual in-service on the Home Free System. All staff was trained on the system. She stated there can be a five to seven second delay when the pad alarms before it reached the pager. She stated if there was a little piece of plastic is broken on the bed pad alarm and staff didn't notice, or a wire was broken, the pad would not go off. She stated pagers had not been working "for a month or so off and on."

A Home Free System representative indicated a tenant's record of monitoring could be reviewed, but only if the tenant had not been deleted from the system. Tenant #1 had already been deleted from the system.

- Regulatory Insufficiency: None noted.

Dated this 25th day of October, 2010.