IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

RODNEY A. ROBERTS, DIRECTOR

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 32072-C

March 3, 2011

Emily Elmendorf, Director
Bickford Cottage of Iowa City
3500 Lower West Branch Road
Iowa City, IA 52245-4106

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

Dear Ms. Elmendorf:

I. Final Complaint Investigation Report – Bickford Cottage of Iowa City, 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 and Iowa Administrative Code (IAC) chapters 481—67 and 481—69. The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation of Tenant, Service Plan, Nurse Review and Other (not following program's own policies and procedures). **Bickford Cottage of Iowa City** ("Program") is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

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 six hundred fifty ($650) 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 $1,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on March 2, 2011, has been reviewed and will constitute the final POC related to the on-site visit of January 3 & 4, 2011.

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 Complaint Investigation Report

Assisted Living Program: **Complaint Intake #: 32072-C**

Emily Elmendorf, Director
Bickford Cottage of Iowa City
3500 Lower West Branch Road
Iowa City, IA 52245

Date of Investigation:

January 3 & 4, 2011

Monitor(s):

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. 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 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 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:

A complaint investigation on-site visit was conducted at Bickford Cottage of Iowa City on January 3, 2011 & January 4, 2011. 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):	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 have been substantiated Regulatory Insufficiencies this certification period in the areas of: Evaluation of Tenants, Service Plan, Food Service, Staffing and Record Checks.

The October 11 and 12, 2010 Recertification, Complaint and Incident Investigation resulted in a civil penalty of $4,000.00 and Regulatory Insufficiencies in the areas of: Evaluation of Tenants, Service Plan, Food Service, Staffing and Record Checks.

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

A. Evaluation of Tenant

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

- Monitoring Observation: Four tenant files were reviewed.

  Tenant #3, a 93 year old, was admitted on 1-31-09 with diagnoses of: Atrial Fibrillation, Benign Prostate Hypertrophy (BPH), Congestive Heart Failure (CHF), Eczema, Hypertension (HTN), Macular Degeneration and Vascular Dementia. The tenant was staged at a four to a five on the Global Deterioration Scale (GDS), which indicated moderate to moderately severe cognitive impairment. According to Progress Notes dated 11-16-10 the tenant hit a window in the private dining room with a chair and broke the window. The tenant was not harmed and police were called. The tenant was transferred to a geriatric psych ward for an evaluation. An evaluation was completed after the tenant returned. Notes from 11-29-10 to 1-2-11 indicated the tenant swung at staff when attempting to redirect, had exit seeking behavior and wandering behavior. The tenant opened doors and disturbed other tenants and had agitated behavior towards another tenant's family member when asked to leave another tenant's apartment. Evaluations were not completed as needed.

  Tenant #4, a 92 year old, was admitted on 11-15-05 with diagnoses of: Cognitive Impairment, Constipation, Dry Eyes, Edema, HTN, Osteoarthritis, Parkinson's Disease and Chronic Urinary Tract Infections (UTIs). The tenant was staged a four on the GDS, which indicated moderate cognitive impairment. Progress Notes dated 11-29-10, indicated the tenant was observed walking "weird" and spoke of frequent delusions. Progress Notes dated 12-14-10 indicated the tenant had increased confusion during the day and the evening had improved. Notes indicated there was a new order for regular food; add three teaspoons thickening powder per 8 oz fluids. The tenant coulod have regular water outside of meals. Notes dated 1-3-11 indicated the nurse practitioner was notified of the tenant's morning behaviors of screaming for help and increased confusion. Evaluations were not completed as needed.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive, and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with a significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

B. Service Plan

Complaint Allegation: It was alleged services were not provided in accordance with the service plans. It was alleged staff did not review service plans.

- Monitoring Observation: Four tenant files were reviewed.

Tenant #1, an 87 year old, was admitted on 4-24-10 with diagnoses of: Advanced Vascular Dementia with Parkinson's Disease, Hypothyroidism, Obstructive Uropathy and Recurrent Constipation. The tenant was staged at a five to six on the GDS, which indicated moderately severe to severe cognitive impairment. The tenant had a physician's order for assist with feeding. Staff #1, #2, #3 and #4 indicated the tenant had a spouse or another private caregiver that assisted the tenant with meals. The service plan did not include the private caregiver/spouse assistance with meals. The service plan did not reflect the needs of the tenants.

Tenant #2, a 75 year old, was admitted on 6-19-09 with diagnoses of: Arthritis, BPH, Barrett's Esophagus, Coronary Artery Disease (CAD), Dementia, Depression, Diverticulitis and Chronic Headaches. The tenant was staged at four on the GDS, which indicated moderate cognitive impairment. The service plan was updated as needed.

Tenant #3's file was reviewed. According to Progress Notes dated 11-16-10 the tenant hit a window in the private dining room with a chair and broke the window. The tenant was not harmed and police were called. The tenant was transferred to a geriatric psych ward for an evaluation. A service plan was updated when the tenant returned. Notes from 11-29-10 to 1-2-11 indicated the tenant swung at staff when attempting to redirect, had exit seeking behavior and wandering behavior. The tenant opened doors and disturbed other tenants and had agitated behavior towards another tenant's family member when asked to leave another tenant's apartment. The tenant's service plan was not updated as needed and did not reflect the needs of the tenant.

Tenant #4's file was reviewed. Progress Notes dated 11-29-10, indicated the tenant was observed walking "weird" and spoke of frequent delusions. Progress Notes dated 12-14-10 indicated the tenant had increased confusion during the day and the evening had improved. Notes indicated there was a new order for regular food; add three teaspoons thickening powder per 8 oz fluids. The tenant could have regular water outside of meals. Notes indicated the nurse practitioner was notified of the tenant's morning behaviors of screaming for help and increased confusion. Notes indicated the tenant received physical therapy and it was discontinued on 12-16-10. The service plan did not include physical therapy.. The tenant's service plan was not updated as needed, did not reflect the needs of the tenant and did not include the outside service provider.

Tenant council meeting minutes for three months were reviewed. The tenants did not voice concerns about cares or services not provided, according to the notes. Three tenants were interviewed and did not express any concerns with cares or services. The tenants did not have any concerns with staff and stated they responded quickly and no improvements were offered. Staff #1, #2, #3 and #4 indicated the tenants received the cares required. Staff #5, the housekeeper, indicated tenants received housekeeping and laundry services as requested.

Staff #1 and #3 stated they reviewed the tenant's service plans. Staff #2 stated she had not read the service plans; however, knew what cares to provide via the Medication Administration Records (MARs), shower list and task sheets. Staff #4 stated she had read the service plans and also knew what to provide via other staff and the communication book.

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. (IAC r. 481-69.26(3))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy. (IAC r. 481-69.26(4)(c))

Complaint Allegation: It was alleged service plans were not signed appropriately.

- Monitoring Observation: Four tenant files were reviewed.

  Tenant #2's file was reviewed. The tenant had a court appointed legal guardian. The most current service plan of 9-16-10 was signed by the tenant's guardian and was signed appropriately. The tenant's previous service plans on 4-23-10 and 3-15-10 were signed by the tenant and a nurse and other staff. The tenant signed the service plans despite having a legal guardian appointed. The service plans were not signed by the appropriate legal representative.

- Regulatory Insufficiency: If a significant change triggers the review and update of a plan, the updated service plan shall be signed and dated by all parties. (IAC r. 481-69.26(3)(a))

C. Medications

Complaint Allegation: It was alleged medications were administered from a pill cup and not from a bubblepack. It was alleged staff left the medication tote unattended. It was alleged staff prepared medications for tenants to take out of the program and kept the medications with staff and not in secure location.

- Monitoring Observation: A medication pass was observed and appropriate protocol was followed.

  The program's Medication Administration policy was reviewed. The policy indicated staff took the unit dose package(s) to the individual tenant, removed from the unit dose package and followed the procedure for administration of medication. The administered medications were stored in the medication room. Staff #1 and #2 indicated staff did not take medications to the tenant's apartments in pills cups. Staff #2 stated staff took the bubblepacks and MARs to the apartments. Staff #3 stated months ago she had removed the medications from the bubblepack and took them in a

medication cup to take to an apartment. She said she was corrected on it months ago and she had not administered medications in that manner since that time.

Staff #1, #2, #3 and #4 stated medications were not left unattended. Staff #1, #2 and #3 stated the medications were within sight. Medications were not left out of sight when the medication pass was observed on 1-3-11.

Staff #1 stated medication was packed in an envelope and given to the tenant's family if the tenant was out of the program when medications were scheduled to be administered. The medications were kept in the medication room and she was not aware of any staff that kept the packed medications with them. Staff #2 stated medications were packed in an envelope with instructions. The medications were kept in the medication room. Staff #3 stated medications were put into an envelope with information on the envelope and it was recorded on the MAR that medications were with family. She stated she did not prepare the medications until the person was there to take the tenant out or if she knew someone was coming to take a tenant out she would put the pills into an envelope and put it in her pocket. She stated there had not been any issues related to this practice. Staff #1, #2 and #3 were Licensed Practical Nurses (LPNs).

According to the Divisional Director of Quality Assurance, the program did not have a written formal policy regarding out of program medications. She stated medications were put into an envelope and the envelope was given to the tenant if appropriate or to the tenant's family. These medications were kept in the medication room.

There was no formal policy pertaining to medications given out of the program.

- Regulatory Insufficiency: None noted.

D. Nurse Review

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

- Monitoring Observation: Four tenant files were reviewed.

  Tenant #1's file was reviewed. Progress Notes dated 11-29-10 indicated the tenant was very weak, had slurred speech and had the shakes. Notes indicated earlier on 11-29-10 the tenant's spouse was concerned the tenant had a stroke. The tenant's hospice nurse was notified; however, a nurse review was not completed. A nurse review was not completed as needed.

  Tenant #2's file was reviewed. A 90 day review had not been completed since 7-19-10. Progress Notes from 12-4-10 to 12-16-10, indicated the tenant had blisters on the right foot and was diagnosed with a blister with infection and cellulitis. Bactrim DS and Keflex were ordered. Nurse reviews were completed; however, they were completed by LPNs and not an Registered Nurse (RN). Nurse review was not completed as needed.

- Regulatory Insufficiency: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

E. Structural requirements

Complaint Allegation: It was alleged the program's front door did not latch and the alarm did sound when the door was not securely latched.

- Monitoring Observation: The monitor observed a sign posted by the front door, which indicated to pull door closed tightly. When the monitor entered the building the front door did not fully latch. A test of the front door was completed. The door code was entered and the door was swung open. The door did not initially fully close; however, after approximately 15 seconds the door reset and was pulled in to fully close. This test was attempted three times and each time the door initially did not close; however, after approximately 15 seconds the door reset and was pulled in to fully close.

Maintenance records were reviewed. On 11-22-10 an entry was recorded that indicated the front door latch was not completely closing. The maintenance staff checked the doors including the front door on 11-17-10, 12-3-10, 12-10-10, 12-13-10, 12-20-10 and 12-28-10. The front door passed inspection related to outdoor keypad, indoor keypad, crash bar and 15 second delay, door closer, delay alarm, bypass key, audible alarm and universal transmitter on the inspection dates.

The maintenance staff was interviewed. He stated there were problems with door seasonally with temperature changes and the door being wood. He stated previously the door would not close all the way because it was sagging and was pulled down. The door would catch on the threshold and the door was registering as open. He tightened up the screws that held the hinges up to repair the door. He said at the time of the investigation the door fully closed and there were no issues with the alarms. He stated the 15 second delay functioned appropriately.

Staff #1, #2 and #4 indicated at the time of the investigation the front door and alarms functioned appropriately. Staff #1, #2 and #3 did not identify any tenants that had eloped in the past three months. An onsite visit was completed in October 2010.

Although the door did not fully latch initially; the door was not found to be out of compliance with the 15 second egress delay.

- Regulatory Insufficiency: None noted.

F. Other

Complaint Allegation: It was alleged medication disposal was not appropriately documented. It was alleged staff were not aware of the medication disposal procedure.

- Monitoring Observation: The program's Medication Disposal policy indicated the program would comply with the following in the disposal of all drugs. Most non-controlled medication would be returned to the pharmacy. The disposal of drugs was recorded on drug disposal form, which included the name, reason for disposal, method of disposal and signature of staff. Controlled medications were disposed of by the RN Coordinator and another individual, as required by the State, and recorded on the disposal sheet as to the method used. The signature of both individuals that witnessed the disposal was recorded.

  Medication Destruction Records were reviewed from 11-1-10 to the time of the investigation. Medications were not consistently destroyed in accordance with the policy. On 11-1-10 one tablet of Tenant #5's Morphine Sulfate 30 mg was destroyed. Two LPNs signed the form; however, the RN Coordinator did not sign the form as required by policy. The method of destruction was not recorded on the form as required by policy. On 11-6-10 24 tablets of Tenant #3's Ativan .5mg were destroyed. Two LPNs signed the form; however, the RN Coordinator did not sign the form as required by policy. The method of destruction was not recorded on the form as required by policy. On 12-2-10 10 tablets of Tenant #2's Darvocet-N 100, one tablet of Vicodin 5/500 mg and one tablet of Xanax .5 mg were destroyed. Two LPNs signed the form; however, the RN Coordinator did not sign the form as required by policy.

  According to a program document, six tenant received narcotics. Three of the six files were reviewed. Tenant #2's Individual Narcotic Records indicated 10 tablets of Darvocet 100/650 were destroyed. This was reconciled appropriately with the amount of tablets destroyed per the Medication Destruction Record.

  The program did not consistently follow the policy and procedure related to medication disposal of narcotics.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by the program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2))

Dated this 2nd day of March, 2011.