IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

DEMAND LETTER
CERTIFIED
Incident Intake #: 31160-I
31508-I

December 13, 2010

Ms. Kathy Savits, Interim Director
Bickford Cottage of Urbandale
5915 Sutton Place
Urbandale, IA 50322

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

Dear Ms. Savits:

I. Final Incident Investigation Report – Bickford Cottage of Urbandale, Urbandale, 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 Regulatory Insufficiencies in the area(s) of: Evaluation of Tenant, Service Plan and Staffing. **Bickford Cottage of Urbandale** ("Program") is being assessed a $1,000 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 six hundred fifty dollars ($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. The Plan of Correction (POC) submitted on December 8, 2010, has been reviewed and will constitute the final POC related to the on-site visit of October 29, 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 Investigation Report

Assisted Living Program:

Kathy Savits, Interim Director
Bickford Cottage of Urbandale
5915 Sutton Place
Urbandale, IA 50322

Incident Intake #: 31160-I
31508-I

Date of Incident Investigation:

October 29, 2010

Monitor(s):

Stephanie Cummins, MA
Ann Martin, RN
Lori Miner, RN BSN

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 of Urbandale on October 29, 2010. In preparing this report, the following information was considered:

Current Program Census:

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):	14
Current number of tenants without cognitive disorder:	19
Total Population:	33

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

Total Population of DSP:	9
Total Census of ALP:	42

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

Program History – The program has had substantiated Regulatory Insufficiencies in the areas of Record Checks, Structural Requirements, Food Service, Evaluation of Tenant, Criteria for Exclusion of Tenants, Nurse Review, Service Plan and Other during this certification period.

The complaint history during this certification period includes the complaints and incident investigation of #29017-C, #29093-C and # 29094-I, with Regulatory Insufficiencies in the areas of: Evaluation of Tenant, Criteria for Exclusion of Tenants, Nurse Review, Service Plan and Other, which resulted in a $1000.00 fine.

The recertification monitoring evaluation report and revisit of #15017-C on July 28 & 29, 2008, with a Regulatory Insufficiency in the area of Record Checks, resulted in a $500.00 fine.

The complaint investigation of #25076-C on September 22, 2009, with a Regulatory Insufficiency in the area of Structural Requirements, resulted in a $500.00 fine.

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: Six tenant files were reviewed.

  Tenant #1, a 62 year old, was admitted on 7-9-10 and diagnoses include Schizophrenia and History of Cerebral Vascular Accident (CVA). The tenant was discharged from the program due to an incident that occurred on 10-23-10. Cognitive and functional evaluations were completed prior to taking occupancy; however, a health evaluation was not completed prior to taking occupancy. Cognitive and functional evaluations were completed within 30 days of taking occupancy; however, a health evaluation was not completed within 30 days of taking occupancy. Health evaluations were not completed prior to and within 30 days of taking occupancy. On 7-8-10 the tenant scored a 21/30 on the Mini Mental Status Examination (MMSE). On 7-28-10 the tenant scored 23/30 on the MMSE. The score from the initial cognitive evaluation indicated the Global Deterioration Scale (GDS) should have been used at subsequent intervals; however, the GDS was not used. According to Progress Notes dated 10-5-10, a staff found the tenant standing over another tenant who was lying on the floor. The staff noticed Tenant#1's hat and cigarette butt can with cigarette butts scattered on the floor. Tenant #1 was also found breathing hard, according to the notes. Tenant #1 stated the other tenant came at him/her and he/she pushed the other tenant away. Tenant #1 stated it was the second time that day the other tenant had come at him/her. The tenant was asked to leave the area and he/she refused. The tenant was transferred to the hospital for a psych evaluation. According to hospital records the tenant was discharged from the hospital on 10-7-10. According to an Incident Report dated 10-23-10 the tenant told staff he/she was going to commit suicide. The tenant cut his/her left hand and was taken to a hospital and did not return to the program. Staff #3 stated the tenant had made comments or suicidal ideations previously. She stated the tenant had said he/she did not want to be here anymore and stated he/she wanted to be in the hospital. She stated the tenant made those comments once in awhile; however, not all of the time. She stated the tenant had not made any comments about actual harm previously. Staff #4 stated the tenant had made comments about wanting to die; however, did not have a plan. He stated the tenant was very unstable and the tenant's mood changed. The nurse stated the tenant had made comments about hurting someone or himself/herself; however, did not have a plan. She stated staff would offer the tenant a PRN medication or a smoke; however, the last couple of weeks the interventions were not successful. Evaluations were not completed prior to taking occupancy, within 30 days of taking occupancy and as needed. The tenant scored moderately on the cognitive tool and the GDS was not used at subsequent intervals.

  Tenant #2, an 87 year old, was admitted on 6-26-06 and diagnoses include: Restless Leg Syndrome (RLS), History of Right Mastectomy, Allergies, Hypertension (HTN) and Dementia. The tenant was staged at a four on the GDS, which indicated moderate cognitive decline. According to an Incident Report dated 10-3-10 the tenant was found on the floor on his/her left side, moaning in pain. The tenant was

taken to the hospital. According to Hospice Interdisciplinary Notes dated 10-3-10, the tenant returned to the program with diagnosis of left hip fracture and the decision was made not to repair the hip. Orders were received to discontinue oral medications and to initiate routine Roxanol and Ativan and PRN doses of Roxanol and Ativan for breakthrough pain. A hi-low bed with mats and a mattress for the tenant arrived on 10-3-10, according to notes. The tenant died on 10-7-10. The nurse indicated the tenant had increased cares after the hip fracture. Staff #2 stated after the hip fracture the tenant seemed weak. Evaluations were not completed as needed.

Tenant #4, an 83 year old, was admitted on 2-9-06 and diagnoses include: Alzheimer's Disease, Osteoporosis, Pure Hypercholesterolemia, Non-Insulin Dependent Diabetes Mellitus (NIDDM) and Vitamin B-12 deficiency. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. The tenant resided in the dementia unit. The tenant was on a waiver from the department. According to Progress Notes dated 10-17-10, a staff requested the nurse assess a red spot on the tenant's right buttock. The nurse found a red closed area without drainage, approximately the size of a pencil eraser. On 10-19-10 the nurse assessed the area and found a red area about the size of a pencil eraser and it was open without drainage. The nurse notified Hospice of the area and requested a hospital bed and air loss mattress to help prevent further skin breakdown, according to notes. On 10-21-10, the nurse assessed the area on right buttock and the area was red but appeared to be healing without drainage. The area had not increased in size. Evaluations were not completed as needed.

- Regulatory Insufficiency: A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluations shall be conducted by a health care professional or human service professional. (IAC r. 481-69.22(1))

- 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

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

- Monitoring Observation: Six tenant files were reviewed.

  Tenant #1's file was reviewed. Progress Notes dated 10-5-10 documented that a staff found the tenant standing over another tenant who was lying on the floor. The staff noticed Tenant#1's hat and cigarette butt can with cigarette butts scattered on the floor. Tenant #1 was also found breathing hard, according to the notes. Tenant #1 stated the other tenant came at him/her and he/she pushed the other tenant away. Tenant #1 stated it was the second time that day the other tenant had come at him/her. The tenant was asked to leave the area and he/she refused. The tenant was transferred to the hospital for a psych evaluation. According to hospital records the tenant was discharged from the hospital on 10-7-10. The service plan was not updated as needed. The tenant's most recent service plan was dated 7-28-10. The service plan indicated (under Behavior) the tenant's behavior was appropriate. According to an Incident Report dated 10-23-10 the tenant told staff he/she was going to commit suicide. The tenant cut his/her left hand and was taken to a hospital and did not return to the program. Staff #3 stated the tenant had made comments or suicidal ideations previously. She stated the tenant had said he/she did not want to be here anymore and stated he/she wanted to be in the hospital. She stated the tenant made those comments once in awhile; however, not all of the time. She stated the tenant had not made any comments about actual harm previously. Staff #4 stated the tenant had made comments about wanting to die; however, did not have a plan. He stated the tenant was very unstable and the tenant's mood changed. The nurse stated the tenant had made comments about hurting someone or himself/herself; however, did not have a plan. She stated staff would offer the tenant a PRN medication or a smoke; however, the last couple of weeks the interventions were not successful. The service plan was not updated as needed and did not identify the tenant's needs and preferences for assistance.

  Tenant #2's file was reviewed. According to an Incident Report dated 10-3-10 the tenant was found on the floor on his/her left side, moaning in pain. The tenant was taken to the hospital. According to Hospice Interdisciplinary Notes dated 10-3-10, the tenant returned to the program with diagnosis of left hip fracture and the decision was made not to repair the hip. Orders were received to discontinue oral medications and to initiate routine Roxanol and Ativan and PRN doses of Roxanol and Ativan for breakthrough pain. A hi-low bed with mats and a mattress for the tenant arrived on 10-3-10, according to notes. The tenant died on 10-7-10. The nurse indicated the tenant had increased cares after the hip fracture. Staff #2 stated after the hip fracture the tenant seemed weak. The tenant's service plan was last updated on 9-23-10, prior to the hip fracture and return to the program without surgical repair of the hip. The service plan was not updated as needed and did not identify the tenant's needs and preferences for assistance.

  Tenant #3, a 71 year old, was admitted on 1-1-04 and diagnoses include Dementia, Depression, Anxiety and Gastroesophageal Reflux Disease (GERD). The tenant was staged at five on the GDS, which indicated moderately severe cognitive decline. Staff #2 stated the tenant had suicidal ideations. She stated the tenant was depressed and would say he/she was going to kill himself/herself. She stated she talked to the tenant and gave the tenant a soda and indicated the tenant came around when staff talked to the tenant. The nurse stated one time the tenant had a suicidal ideation; however, she did not feel it was a true threat and the tenant was not hospitalized. The

tenant's service plan did not address this behavior. The service plan did not identify the tenant's identified needs and preferences for assistance.

Tenant #4's file was reviewed. According to Progress Notes dated 10-17-10, a staff requested the nurse assess a red spot on the tenant's right buttock. The nurse found a red closed without drainage and the area was approximately the size of a pencil eraser. On 10-19-10 the nurse assessed the area and found a red area about the size of a pencil eraser and it was open without drainage. The nurse notified Hospice of the area and requested a hospital bed and air loss mattress to help prevent further skin breakdown, according to notes. On 10-21-10 the nurse assessed the area on right buttock and the area was red but appeared to be healing without drainage. The area had not increased in size. The tenant's service plan was last updated on 8-10-10. The tenant's service plan was not updated as needed and did not identify the tenant's identified needs and preferences for assistance.

- 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 tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

C. Staffing

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

Monitoring Observation: Tenant #1's file was reviewed. Progress Notes dated 10-5-10, a staff found the tenant standing over another tenant who was lying on the floor. The staff noticed Tenant#1's hat and cigarette butt can with cigarette butts scattered on the floor. Tenant #1 was also found breathing hard, according to the notes. Tenant #1 stated the other tenant came at him/her and he/she pushed the other tenant away. Tenant #1 stated it was the second time that day the other tenant had come at him/her. The tenant was asked to leave the area and he/she refused. The tenant was transferred to the hospital for a psych evaluation. According to hospital records the tenant was discharged from the hospital on 10-7-10. The service plan was not updated as needed. The tenant's most recent service plan was dated 7-28-10. The service plan indicated (under Behavior) the tenant's behavior was appropriate. According to an Incident Report dated 10-23-10 the tenant told staff he/she was going to commit suicide. The tenant cut his/her left hand and was taken to a hospital and did not return to the program. Staff #3 stated the tenant had made comments or suicidal ideations previously. She stated the tenant had said he/she did not want to be here anymore and stated he/she wanted to be in the hospital. She stated the tenant made those comments once in awhile; however, not all of the time. She stated the tenant had not made any comments about actual harm previously. Staff #4 stated the tenant had made comments about wanting to die; however, did not have a plan. He stated the tenant was very unstable and the tenant's mood changed. The nurse stated the tenant had made comments about hurting someone or himself/herself; however, did not have a plan. She stated staff would offer the tenant a PRN medication or a

smoke; however, the last couple of weeks the interventions were not successful. The tenant's needs were not met.

Tenant #3's file was reviewed. Staff #2 stated the tenant had suicidal ideations. She stated the tenant was depressed and would say he/she was going to kill himself/herself. She stated she talked to the tenant and gave the tenant a soda and indicated the tenant came around when staff talked to the tenant. The nurse stated one time the tenant had a suicidal ideation; however, she did not feel it was a true threat and the tenant was not hospitalized. The tenant's needs were not met.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet the tenants' identified needs. (IAC r. 481-67.9(1))

D. Other

Incident Allegation #31160-I: The program reported a tenant was found on the floor and was moaning in pain. The tenant was sent to the hospital and was diagnoses with a left hip fracture.

- Monitoring Observation: Tenant #2's file was reviewed. According to an Incident Report dated 10-3-10 at 4:45 a.m. Tenant #2 was found on the floor on his/her left side, moaning in pain. The tenant was taken by ambulance to the hospital.

  Staff #5 worked when the incident occurred. Staff #5 stated her pager went off and indicated the tenant's pad alarm went off. She responded immediately and before she got there she heard a loud noise. She found the tenant on the floor on the left side and the tenant was moaning. She did not move the tenant and staff called the former nurse. The former nurse said he was going to call 911 and asked staff to get the paperwork ready. Staff put a pillow under the tenant's head and one staff stayed with the tenant. The tenant was checked 30 minutes prior to incident and was sleeping at that time. She stated the tenant had a companion service at night; however, they were not there that night. She stated there was an appropriate response from staff related to the incident.

  According to Hospice Interdisciplinary Notes dated 10-3-10, the tenant returned to the program with diagnosis of left hip fracture and the decision was made not to repair the hip. Orders were received to discontinue oral medications and to initiate routine Roxanol and Ativan and PRN doses of Roxanol and Ativan for breakthrough pain. A hi-low bed with mats and a mattress for the tenant arrived on 10-3-10, according to notes. The tenant died on 10-7-10.

  Evaluations and service plans were not updated as needed as indicated above. Staff did not meet the identified needs of the tenant as indicated above.

  The program reported the incident to the department appropriately. An incident report was completed related to the incident.

- Regulatory Insufficiency: None noted.

Incident Allegation #31508-I: The program reported a tenant notified staff he/she was going to commit suicide by cutting himself/herself with a razor. It was reported staff notified the nurse and the nurse instructed staff to go to the tenant's apartment and remove all razors. It was reported when staff went to the tenant's apartment he/she was not in the room; however, the tenant was found in the hallway and staff noticed his/her left arm bleeding. It was reported the police and Emergency Medical Technicians (EMTs) arrived and the tenant was treated and sent to the hospital for evaluation.

- Monitoring Observation: Tenant #1's file was reviewed. According to an Incident Report dated 10-23-10 at 6:25 p.m. Tenant #1 told staff he/she was going to commit suicide. Staff called the nurse and nurse instructed staff to look for razors in the tenant's room as the tenant had stated he/she wanted to "smash …face with razor." Staff went to the tenant's apartment; however, the tenant went to the apartment before staff could get the razor. Staff looked for the tenant and found him/her in the hallway and at that time the tenant had cut his/her left hand and was bleeding. Staff tried to calm the tenant down; however, the tenant was very upset and wanted to hurt himself/herself. The tenant kept running away from staff and would not give staff the razors. The nurse arrived and calmed the tenant down and convinced the tenant to hand over the razors. The ambulance and police arrived and the tenant was taken to the hospital and police took statements from staff.

  Staff #3 worked when the incident occurred. She said the tenant came up to her and said he/she was going to kill himself/herself. She called the nurse and the nurse asked her what was the tenant's plan. The tenant said there were razors in the tenant's apartment. The nurse told her to get the razors from the tenant's apartment. Staff #3 called another staff and the tenant left. Staff went to the tenant's apartment and noticed blood spots in the tenant's bathroom and razor covers all over. Staff found the tenant in the hallway by the whirlpool room and he/she had cut his/her hand. Staff tried to calm the tenant down and the tenant refused to hand over the razors. She called the nurse again and the nurse was on the way. The tenant went back to the tenant's apartment and staff went with the tenant. The tenant handed a razor to staff. The nurse arrived and tried to make a deal with the tenant. The nurse called 911 and they took the tenant to the hospital. She stated it took approximately five minutes from when the tenant first told her he/she wanted to commit suicide to when the tenant was found in the hallway by the whirlpool room.

  The nurse stated she received a call from staff who said the tenant stated he/she was going to commit suicide. The nurse asked staff to ask the tenant if he/she had a plan. The tenant said he/she had razors. The nurse told staff to keep someone with the tenant and send someone else to retrieve razors. Staff called the nurse back and reported the tenant had got back to the room before staff and they found him/her in the hallway and the tenant was bleeding. The nurse arrived in the building before 7:00 p.m. and the tenant stated he/she wanted to go to the hospital. The tenant would not allow staff to get vitals or look at his/her arm and she observed multiple cuts on the tenant's left forearm and hand. The tenant eventually let the nurse look at the arm. The tenant eventually turned over all of the razors and 911 was called. The police and EMTs arrived and the tenant allowed them to wrap the arm and obtain vitals. The tenant went willingly to the hospital. Due to the incident on 10-23-10 the tenant did not return to the program.

Evaluations and service plans were not updated as needed as indicated above. Staff did not meet the identified needs of the tenant as indicated above.

The program reported the incident to the department appropriately. An incident report was completed related to the incident.

- Regulatory Insufficiency: None noted.

Dated this 13th day of December, 2010.