IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 33160-M

June 10, 2011

Maria Pena Coulter, Director
Bickford Cottage Assisted Living
4040 55th Street
Davenport, IA 52806

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

Dear Ms. Coulter:

I. Final Incident Investigation Report – Bickford Cottage Assisted Living, Davenport, 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: Staffing, Tenant Rights and Other (non notification of DAA). **Bickford Cottage Assisted Living** ("Program") is being assessed a $3,000 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 **Jim Berkley** and remit the civil penalty assessed by check or money order in the amount of one thousand nine hundred and fifty dollars ($1950) 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 $3,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on June 8, 2011, has been reviewed and will constitute the final POC related to the on-site visit of April 12-14, April 18-19 and May 3, 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, Jim Berkley, at 515/281-4116.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint/Incident Intake #:** 33160-M

Maria Pena Coulter, Director
Bickford Cottage Assisted Living
4040 55th Street
Davenport, IA 52806

Date of Investigation:

April 12 – 14, April 18-19 and May 3 2011

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 a Complaint/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:

A complaint/incident investigation on-site visit was conducted at Bickford Cottage Assisted Living on 4- 12 – 14, 18 & 19 and 5-3-11. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that does is not include a Dementia Specific unit, but may include have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	13
Current number of tenants with cognitive disorder:	6
Total Population of GPP:	19

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

Total Population of DSP:	4
Total Census of ALP:	23

***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 Evaluation of the Tenant, Criteria for Evaluation of the Tenants, Tenant Documents, Service Plan, Nurse Review, Staffing and Tenant Rights.

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

Complaint/Incident Investigation – The complaint/incident investigator(s) made the observations detailed in the following areas.

A. Staffing

Complaint/Incident Allegation #33160-M: It was alleged Staff #1, #2 and #3 used profanity, raised their voices and frightened tenants.

It was alleged Tenant #1 was picked on by Staff #1, #2 and #3. Staff brought these concerns to the attention of the Director and nothing was done. It was alleged the tenant would ask for his/her meal and Staff #1, #2 and #3 would tell the tenant he/she would be served last or sent to his/her apartment. It was alleged Staff #1 grabbed tenant #1's arm and pushed him/her into a chair.

- Monitoring Observation: On 2-28-11 the program received allegations of verbal and physical abuse of tenants. An internal investigation was completed on 3-1 & 3-2-11 and concluded Staff #1, #2 and #3, for months, acted inappropriately toward Tenant's #1, #2 and #3. Staff had exhibited verbal and physical aggression toward tenants, used profanity in the presence of tenants and withheld tenant's food. The program terminated employment of Staff #1 and #3 on 3-7-11 and Staff #2 was terminated 3-9-11.

  Tenant #1, a 78 year old, was admitted on 5-31-03 and had diagnoses of: Alzheimer's disease and Mild Dementia. A global deterioration scale (GDS) was completed on 3-11-11 and staged the tenant at four-five, which indicated moderate to moderately severe cognitive decline. The tenant resided in the general population. A service plan of 3-11-11 revealed the tenant was resistant to staff assistance with personal and health related cares. The tenant would resist redirection, became agitated, defensive and argumentative. Staff were directed to smile, speak pleasantly in a cheerful voice and offer alternatives. The tenant was to be served first at meals and staff were to offer snacks throughout the day.

  Staff #4, #5, #6 and #7 reported incidents of daily confrontations between the Staff #1, #2 and #3 and Tenant #1. Staff #4 reported Staff #1 threatened the tenant he/she wouldn't receive a meal. The tenant would be served last and Staff #1 would point her finger and yell at the tenant.

  Staff #5 reported Staff #1, #2 and #3 would yell and humiliate tenant #1 at every meal. Staff #1, #2 and #3 would purposely skip over tenant #1 and would serve tenant #1 last. Staff #1, #2 and #3 would get in tenant #1's face, so close, there would be inches between them and tell tenant #1 to sit "the fuck down," otherwise he/she wouldn't eat at all. Staff #1, #2 and #3 would put their hands on tenant #1 and helped them to sit down.

  Staff #6 reported Staff #1, #2 and #3 would tell tenant #1 to "sit ... ass down," and they then would serve tenant #1 last. Staff #1, #2 and #3 would put their hands in front of tenant#1's face and tell the tenant to go back to his/her room until they were ready to serve him/her. Staff #7 reported Staff #1, #2 and #3 told tenant #1 he/she wouldn't receive his/her meal because they didn't like the tenant.

  Staff #8 reported an incident on 1-21-11, Staff #1 told tenant #1 to sit down. Tenant #1 did not sit down and Staff #1 grabbed the tenant by the arm and told the tenant to sit down again. Tenant #1 said "don't touch me." Staff #1 grabbed tenant #1 by both arms and tried to make the tenant sit in a chair. The tenant began fighting with Staff #1 and told her not to touch him/her. Staff #1, #2 and #3 would serve the tenant last for breakfast and lunch. Staff #8 reported Staff #1 and #3 had called Tenant #1 a "bitch" in front of other tenants.

  Tenant #4, was admitted on 10-12-09 and is identified with a GDS of 2 revealing no cognitive impairment. Tenant #4 reported Staff #1 would put them in his/her place and would point her finger at tenant #4 to be hurtful. Staff #1 often told tenant #4 to "get "your ass" back in the chair. Staff #1 was mean spirited. There was one incident when Staff #1 forced tenant #4 back into his/her chair. This incident occurred before tenant #4 left the program. Tenant #4 didn't remember the date in which the incident occurred.

Tenant #4 was often served last, yet his/her service plan of 2-16-11 & 3-11-11 revealed the tenant was to be served first. The service plan revealed specific interventions related to tenant #4's behavior, however, Staff #1, #2 and #3's actions were contrary to established interventions. Tenant #4 was discharged from the program and resides in a nursing facility in an adjacent state.

Complaint/Incident Allegation #33160-M: It was alleged Staff #3 snatched a bowl away from Tenant #2 and then grabbed the tenant's arm "roughly."

- Monitoring Observation: Tenant #2, a 79 year old, was admitted on 11-5-04 and had diagnoses of: Senile Dementia, Alzheimer's disease, Hiatal Hernia, History of Myocardial Infarction and Gastro Esophageal Reflux Disease. A global deterioration scale was completed on 10-12-10 and staged the tenant at five, which indicated moderately severe cognitive decline. The tenant resided in the general population. A service plan of 10-12-10 revealed the tenant would get upset and raise his/her voice at staff and tenants during cares and activities. The tenant had a history of striking out, grabbing staff when agitated. Staff were directed to reassure the tenant everything was okay, remind him/her to lower his/her voice, divert the tenant from the situation, by walking them to his/her room or another activity. Should the tenant escalate, staff were to keep a safe distance from the tenant, divert and engage with another activity.

  Staff #4 reported sometime in the winter of 2009, Tenant #2 was seated in the dining room at lunch time. Staff #3 noticed tenant #2 had eaten another tenant's coleslaw, reached for another when she took the coleslaw from the tenant and told the tenant he/she couldn't have it. Tenant #2 raised his/her arm up and Staff #3 grabbed the tenant's wrist and twisted it slightly. Tenant #2 became agitated and yelled. Staff #3 then let go of the tenant's wrist. Staff #9 reported a similar incident occurred in the summer of 2009.

  The service plan revealed specific interventions related to tenant #2's behavior, however, Staff #1, #2 and #3's actions were contrary to established interventions. Nurse's notes of 11-7-10 revealed tenant #2 was sent to a local hospital emergency room for a psychiatric evaluation and was later transferred to a nursing facility in an adjacent stated. The tenant passed away on 4-17-11.

Complaint/Incident Allegation #33160-M: It was alleged Staff #1, #2 and #3 were seen being "very aggressive, yelled, pointed their finger in Tenant #3's face and raised their voices to scare him/her. It was alleged Tenant #3 was threatened by Staff #1, "If you hit me with that your ass is going to be on the floor."

- Monitoring Observation: Tenant #3, a 77 year old, was admitted on 10-19-03 and had diagnoses of: Paranoid Schizophrenia and Hypothyroidism. A global deterioration scale was completed on 3-31-11, staged the tenant at five-six, which indicated moderately severe to severe cognitive decline. The tenant resided in the general population. A service plan of 3-31-11 revealed the tenant would try and monopolize staff time with concerns and paranoid ideas. Staff were to immediately set parameters with the tenant regarding how long they were to talk with the tenant. Staff were not to minimize concerns and if the tenant became agitated, staff were to remind the tenant to stay calm and not to raise his/her voice. During episodes of agitation, staff were to redirect tenant #3 to return to his/her apartment.

An incident report of 1-18-11 revealed Staff #2 reported tenant #3 was sitting in front of the medication room, arguing with Tenant #4. Tenant #3 was calling Tenant #4 names and accusing him/her of stealing. Staff #1 asked if tenant #3 would go to his/her room and cool off and see if he/she misplaced the item. Tenant #3 became upset, got up and rammed his/her walker into Staff #1 and became aggressive. Staff #5 reported she witnessed the incident of 1-18-11. She reported she saw Staff #1 push tenant #3 back.

Staff #4 reported Staff #1 would be argumentative with tenant #3. Staff #1 would often point her finger in the tenant's face and threaten he/she would be taken by ambulance and evaluated. Staff #1 would yell at tenant #3 and threatened to send them back to his/her room without breakfast or lunch.

Staff #6 reported Staff #1 would argue with tenant #3 to sit down and said she wasn't going to take this "shit" much longer. Staff #1 would get up close to tenant #3 and invade his/her space and has told the tenant he/she was "nasty." Staff #1, #2 and #3 would refuse to clean tenant #3's eating area and other staff had to clean the area.

Staff #7 reported he worked every other weekend with Staff #1, #2 and #3 and they would tell tenant #3 they wouldn't receive his/her meal because they didn't like them.

The service plan revealed specific interventions related to tenant #3's behavior, however, Staff #1, #2 and #3's actions were did not follow established interventions.

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

B. Tenant Rights

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

Staff #4, #5, #6 and #7 reported incidents of daily confrontations between the Staff #1, #2 and #3 and Tenant #1. Staff #4 reported Staff #1 threatened the tenant he/she would receive a meal. The tenant would be served last and Staff #1 would point her finger and yell at the tenant.

Staff #5 reported Staff #1, #2 and #3 would yell and humiliate the tenant at every meal. Staff #1, #2 and #3 would purposely skip the tenant and would serve the tenant last. Staff #1, #2 and #3 would get in the tenant's face, so close, there would be inches between them and tell the tenant to sit "the fuck down," otherwise he/she wouldn't eat at all. Staff #1, #2 and #3 would put their hands on the tenant and helped the tenant to sit down.

Staff #6 reported Staff #1, #2 and #3 would tell the tenant to "sit … ass down," and would be served last. Staff #1, #2 and #3 would put their hands in front of the tenant's face and tell the tenant to go back to his/her room until they were ready to serve him/her. Staff #7 reported Staff #1, #2 and #3 told the tenant he/she wouldn't receive his/her meal because they didn't like the tenant.

Staff #8 reported and incident on 1-21-11, Staff #1 told the tenant to sit down. The tenant did not sit down and Staff #1 grabbed the tenant by the arm and told the tenant to sit down again. The tenant said "don't touch me." Staff #1 grabbed the tenant by both arms and tried to make the tenant sit in a chair. The tenant began fighting with Staff #1 and told her not to touch him/her.

Staff #1, #2 and #3 would serve the tenant last for breakfast and lunch. Staff #8 reported Staff #1 and #3 had called Tenant #1 a "bitch" in front of other tenants.

Tenant #4, reported Staff #1 would put the tenant in his/her place and would point her finger at the tenant to be hurtful. Staff #1often told the tenant to "get "your ass" back in the chair. Staff #1 was mean spirited. There was one incident when Staff #1 forced the tenant back into his/her chair. This incident happened toward the end, before the tenant left the program, but Tenant #4 didn't remember the date in which the incident occurred.

Tenant #2 would get upset and raised his/her voice at staff and tenants during cares and activities. Staff #4 reported sometime in the winter of 2009, Tenant #2 was seated in the dining room at lunch time. Staff #3 noticed the tenant had eaten another tenant's cole slaw, reached for another when she took the cole slaw from the tenant and told the tenant he/she couldn't have it. Tenant #2 raised his/her arm up and Staff #3 grabbed the tenant's wrist and twisted it slightly. The tenant became agitated and yelled. Staff #3 then let go of the tenant's wrist. Staff #9 reported a similar incident occurred in the summer of 2009.

Tenant #3's service plan of 3-31-11 revealed the tenant would try and monopolize staff time with his/her concerns and paranoid ideas. Staff were to immediately set parameters with the tenant regarding how long they were to talk with the tenant. Staff were not to minimize concerns. If the tenant became agitated, staff were to remind him/her to stay calm and not to raise his/her voice. During episodes of agitation, staff redirected the tenant him/her to return to his/her apartment.

An incident report of 1-18-11 revealed Staff #2 reported the tenant was sitting in front of the medication room, arguing with Tenant #4. The tenant was calling Tenant #4 names and accusing him/her of stealing. Staff #1 asked if the tenant would go to his/her room and cool off and see if he/she misplaced the item. The tenant became upset, got up and rammed his/her walker into Staff #1 and became aggressive. Staff #5 reported she witnessed the incident of 1-18-11. She reported she saw Staff #1 push the tenant back.

Staff #4 reported Staff #1 would be argumentative with the tenant. Staff #1 would often point her finger in the tenant's face and threaten he/she would be taken by ambulance and evaluated. Staff #1 would yell at the tenant and threatened to send the tenant back to his/her room without breakfast or lunch.

Staff #6 reported Staff #1 would argue with the tenant to sit down and said she wasn't going to take this "shit" much longer. Staff #1 would get up close to the tenant and invade his/her space and has told the tenant he/she was "nasty." Staff #1, #2 and #3 would refuse to clean the tenant's eating area and other staff had to clean the area.

Staff #7 reported he worked every other weekend with Staff #1, #2 and #3 and they would tell the tenant he wouldn't receive his/her meal because they didn't like him. The service plan revealed specific interventions related to the tenant's behavior, however, Staff #1, #2 and #3's actions were contrary to established interventions.

Staff #1, #2 and #3 did not treat tenants with consideration, respect, dignity and were mentally and physically abusive.

- Regulatory Insufficiency: All tenants have the following rights: To be treated with consideration, respect, and full recognition of personal dignity and autonomy. To receive care, treatment and services which are adequate and appropriate, to be free from mental and physical abuse and to receive from the manager and staff of the program a reasonable response to all requests. (IAC r. 481– 67.3(1)(2)(4)&(5))

C. Other

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

- Monitoring Observation: Program documentation revealed on 2-28-11, the dietary manager notified the program's human resources department staff had committed physical and verbal abuse toward tenants residing at the program. The program notified the department on 3-7-11, but not within 24 hours of when dependent adult abuse had been reported.

- Regulatory Insufficiency: A staff member or employee of a facility or program, who, in the course of employment, examines, attends, counsels, or treats a dependent adult in a facility or program and reasonably believes the dependent adult has suffered dependent adult abuse, shall report the suspected dependent adult abuse to the department. (235E.2.2)

Dated this 10th day of June, 2011.