IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

RODNEY A. ROBERTS, DIRECTOR

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 33881-C

July 12, 2011

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

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

Dear Ms. Elmendorf:

I. Final Complaint Investigation Report – Bickford Cottage, 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, Tenant Documents, Service Plan, Nurse Review and Other (Tenant Rights). **Bickford Cottage** ("Program") is being assessed a $4,000 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 twenty six hundred dollars ($2600) 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 $4,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on June 29, 2011, has been reviewed and will constitute the final POC related to the on-site visit of May 25 & 26, 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 #: 33881-C**

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

Date of Investigation:

May 25 & 26, 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 on May 25 & 26, 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:	27
Total Population:	35

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

Program History –The Complaint Investigation of January 3 and 4, 2011, resulted in a civil penalty of $1,000.00 and regulatory insufficiencies in the areas of: Evaluation, Service Plan, Nurse Review and Policy and Procedure.

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.

Complaint Investigation – The complaint investigator(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: Eight tenant files were reviewed.

  Tenant #1, an 89 year old, was admitted on 11-12-10 and diagnoses include: Dementia, Hyperlipidemia, Anxiety, Osteoporosis and Upper Gastrointestinal (GI) Bleed. The tenant was staged at a three to four on the Global Deterioration Scale (GDS), which indicated mild to moderate cognitive decline. Cognitive and health evaluations were not completed within 30 days of occupancy.

  Tenant #2, an 89 year old, was admitted on 11-12-10 and diagnoses include: Hypertension (HTN), Prostate Cancer (CA), Benign Prostrate Hypertrophy (BPH) and Memory Loss. Cognitive and health evaluations were not completed within 30 days of occupancy.

Tenant #3, an 85 year old, was admitted on 3-26-11 and diagnoses include: HTN, Atrial Fibrillation, Alzheimer's Dementia, Disequilibrium, Hyperlipidemia, Cognitive Impairment and Urinary Incontinence. The tenant was staged at four to five on the GDS, which indicated moderate to moderately severe cognitive decline. The tenant was discharged on 5-4-11. Progress Notes from 3-29-11 to 4-30-11 indicated entries of physical and verbal aggression towards staff, other tenants and a volunteer. The notes indicated the tenant refused cares, was agitated and combative. On 4-11-11 the tenant indicated he/she had five ways to kill himself/herself. The tenant was sent to the emergency room (ER) and returned the same day. Notes indicated on 4-20-11 the tenant had increased difficulty with ambulation and on 4-21-11 was noted to be stumbling and struggling to walk. On 4-22-11 a walker was ordered and Trazadone was changed to 25 mg twice daily. Physical therapy (PT) was ordered; however, due to physical and verbal aggression the tenant was not admitted. On 4-30-11 the tenant hit the staff person in the stomach, arms and thighs. The tenant began to laugh and scream hysterically and made foreign noises, according to notes. The tenant kicked the staff person in the stomach, hit the staff person again and spit in the staff person's face. According to notes, 911 was called. The police arrived and talked to the tenant. The tenant threw a pillow at the police twice. An ambulance was called and the tenant struck the ambulance medic two to three times before entering the ambulance, according to notes. The tenant was admitted to the geriatric psych unit. Evaluations were not completed within 30 days or as needed.

Tenant #4, a 94 year old, was admitted on 1-31-09 and diagnoses include: Atrial Fibrillation, BPH, Congestive Heart Failure (CHF), Eczema, HTN, Macular Degeneration, Pain, Stroke and Vascular Dementia. The tenant was staged at a six on the GDS, which indicated severe cognitive decline. Progress Notes from 2-20-11 to 3-27-11 indicated the tenant urinated on the floor in his/her bathroom, in the plant in the common area and on the washer in the laundry room. Notes indicated the tenant hit a staff, entered other apartments, was verbally abusive towards staff and was found in the dining room wearing only a protective undergarment. Evaluations were not completed as needed.

Tenant #5, an 89 year old, was admitted on 6-21-03 and diagnoses include: Borderline Diabetes Mellitus (DM), Depression, HTN, Congestion, Constipation and Confusion (Mild). The tenant was staged at a five on the GDS, which indicated moderately severe cognitive decline. The tenant was discharged on 4-6-11. Progress Notes from 2-25-11 to 4-3-11 indicated the tenant received hospice services, had physically and verbally aggressive behaviors towards staff, had increased cares and a need for 24 hour care from an outside agency until nursing home placement was found. Evaluations were not completed as needed.

Tenant #6, a 69 year old, was admitted on 1-8-11. (Diagnoses were not found in the file.) The tenant was staged at five to six on the GDS, which indicated moderately severe to severe cognitive decline. Progress Notes from 2-14-11 to 5-16-11 indicated the tenant had bowel incontinence, refused cares, continuously walked around the building, had changed behaviors and the tenant's apartment was found with towels and a cat bed in the toilet and urine and feces covered the sink, floor and toilet. A functional evaluation was not completed as needed. Cognitive and health evaluations

were completed; however, they were not completed until 5-4-11 and 5-5-11 despite entries in the notes from 2-14-11. 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 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. Criteria for Exclusion of Tenants

Complaint Allegation: It was alleged a tenant was aggressive towards another tenants.

- Monitoring Observation: Incident reports for the last three months and eight tenant files were reviewed.

Tenant #3's file was reviewed. Progress Notes from 3-29-11 to 4-30-11 indicated entries of physical and verbal aggression towards staff, other tenants and a volunteer. The notes indicated the tenant refused cares, was agitated and combative. On 4-11-11 the tenant indicated he/she had five ways to kill himself/herself. The tenant was sent to the ER and returned the same day. Notes indicated on 4-20-11, the tenant had increased difficulty with ambulation and on 4-21-11 was noted to be stumbling and struggling to walk. On 4-22-11 a walker was ordered and Trazadone was changed to 25 mg twice daily. PT was ordered; however, due to physical and verbal aggression the tenant was not admitted. On 4-30-11 the tenant hit a staff person in the stomach, arms and thighs. The tenant began to laugh and scream hysterically and made foreign noises, according to notes. The tenant kicked the staff person in the stomach, hit the staff person again and spit in the staff person's face. According to notes, 911 was called. The police arrived and talked to the tenant. The tenant threw a pillow at the police twice. An ambulance was called and the tenant struck the ambulance medic two to three times before entering the ambulance, according to notes. The tenant was admitted to the geriatric psych unit. The tenant was discharged at the time of the investigation.

Tenant #4's file was reviewed. Progress Notes from 2-20-11 to 3-27-11 indicated the tenant urinated on the floor in his/her bathroom, in the plant in the common area and on the washer in the laundry room. Notes indicated the tenant hit a staff, entered other apartments, was verbally abusive towards staff and was found in the dining room wearing only a protective undergarment. The tenant was not currently discharged; however, was out of the program at the time of investigation and the tenant's apartment was held.

Staff #1, #2 and #3 stated Tenant #3 had been physically or verbally aggressive toward staff. Staff #1 and #2 stated the tenant had been physically aggressive toward other tenants. Staff #2 stated Tenant #4 was aggressive at times; however, the behaviors were manageable. Staff #1, #2 and #3 did not identify any other tenants

that were aggressive towards staff or other tenants. None of the current tenants exceeded the appropriate level of care related to aggressive behaviors.

- Regulatory Insufficiency: None noted.

C. Tenant Documents

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

- Monitoring Observation: Incident reports for the last three months were reviewed. Tenant #3's file was reviewed. According to Progress Notes there were incidents that involved Tenant #3 and other tenants. Progress Notes dated 4-4-11 indicated Tenant #3 slapped the hand of another tenant in exercise that morning. There was no injury to the tenant, according to the notes. According to notes, on 4-24-11 Tenant #3 hit another tenant and yelled for the tenant to wake up. The tenant was struck multiple times. Tenant #3 also hit the house cat three times. According to Progress Notes dated 4-27-11, it was reported by another tenant that on 4-26-11 before lunch Tenant #3 grabbed Tenant #7 around the neck, shook the tenant twice and let the tenant go when the other tenant screamed. The notes indicated it was not witnessed by staff. Incident reports were not found related to the incidents indicated above.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record) (IAC r. 481-69.25(1)(o))

D. Service Plan

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

- Monitoring Observation: Eight tenant files were reviewed.

  Tenant #1's file was reviewed. The preliminary service plan indicated the tenant received a whirlpool for bathing. A functional evaluation indicated the tenant did not like showers and needed assistance. (The whirlpool did not function at the time of the investigation.) The service plan indicated the tenant was independent with medications and staff asked in the morning if medications were taken. The April 2011 Medication Administration Record (MAR) indicated the tenant self administered medications. The service plan was not developed within 30 days of taking occupancy and did not indicate the tenant's identified needs and preferences for assistance.

  Tenant #2's file was reviewed. The preliminary service plan indicated the tenant required assistance for bathing. The functional evaluation indicated the tenant required assistance with a whirlpool and shampoo. (The whirlpool did not function at the time of the investigation.) The service plan was not developed within 30 days of taking occupancy did not indicate the tenant's identified needs and preferences for assistance.

Tenant #3's file was reviewed. A service plan was not developed prior to occupancy. Progress Notes from 3-29-11 to 4-30-11 indicated entries of physical and verbal aggression towards staff, other tenants and a volunteer. The notes indicated the tenant refused cares, was agitated and combative. On 4-11-11 the tenant indicated he/she had five ways to kill himself/herself. The tenant was sent to the ER and returned the same day. Notes indicated on 4-20-11, the tenant had increased difficulty with ambulation and on 4-21-11 was noted to be stumbling and struggling to walk. On 4-22-11 a walker was ordered and Trazadone was changed to 25 mg twice daily. PT was ordered; however, due to physical and verbal aggression the tenant was not admitted. On 4-30-11 the tenant hit a staff person in the stomach, arms and thighs. The tenant began to laugh and scream hysterically and made foreign noises, according to notes. The tenant kicked the staff person in the stomach, hit the staff person again and spit in the staff person's face. According to notes, 911 was called. The police arrived and talked to the tenant. The tenant threw a pillow at the police twice. An ambulance was called and the tenant struck the ambulance medic two to three times before entering the ambulance, according to notes. The tenant was admitted to the geriatric psych unit. The tenant was discharged at the time of the investigation. A service plan was not developed prior to taking occupancy and was not updated within 30 days or as needed. The service plan did not indicate the tenant's identified needs and preferences for assistance.

Tenant #4's file was reviewed. Progress Notes from 2-20-11 to 3-27-11 indicated the tenant urinated on the floor in his/her bathroom, in the plant in the common area and on the washer in the laundry room. Notes indicated the tenant hit a staff, entered other apartments, was verbally abusive towards staff and was found in the dining room wearing only a protective undergarment. The service plan was not updated as needed and did not indicate the tenant's identified needs and preferences for assistance.

Tenant #5's file was reviewed. Progress Notes from 2-25-11 to 4-3-11 indicated the tenant received hospice services, had physically and verbally aggressive behaviors towards staff, had increased cares and a need for 24 hour care from an outside agency until nursing home placement was found. The tenant's service plan indicated staff was to provide a physical assist with whirlpool bathing to ensure all the old cream and ointments and soap were removed to help the tenant not itch. The plan indicated to return to the whirlpool as soon as possible (service plan updated 2-14-11). The whirlpool did not function at the time of the investigation. The tenant's service plan was not updated as needed and did not indicate the tenant's identified needs and preferences for assistance.

Tenant #6's file was reviewed. Progress Notes from 2-14-11 to 5-16-11 indicated the tenant had bowel incontinence, refused cares, continuously walked around the building, had changed behaviors and the tenant's apartment was found with towels and a cat bed in the toilet and urine and feces covered the sink, floor and toilet. The tenant's service plan was not updated as needed. The tenant's service plan (under Toileting) was blank. The functional evaluation dated 2-14-11 indicated a bowel management plan would be developed. The service plan was not updated as needed and did not indicate the tenant's identified needs and preferences for assistance.

- Regulatory Insufficiency: Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. (IAC r. 481-69.26(2))

- 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))

E. Nurse Review

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

- Monitoring Observation: Eight tenant files were reviewed.

  Tenant #1's file was reviewed. A 90 day health review was not completed every 90 days.

  Tenant #2's file was reviewed. A 90 day health review was not completed every 90 days.

  Tenant #4's file was reviewed. The tenant had an order for Trazadone 100 mg one tablet by mouth at bedtime. According to the MAR, the medication was ordered on 11-30-10. An order was received on 2-9-11 to add Trazadone 50 mg by mouth at bedtime. The order was not noted. The February, March and April 2011 MARs indicated Tradzadone 100 mg one tablet by mouth at bedtime was administered. The medication was not given consistent with physician orders.

  Tenant #7, an 89 year old, was admitted on 6-6-09 and diagnoses include: Anxiety, Dementia, HTN, Osteoporosis, Hyperlipidemia, Hiatal Hernia, Gastroesophageal Reflux Disease (GERD), History of Appendectomy and History of Blood Clots. The tenant was staged at five on the GDS, which indicated moderately severe cognitive decline. According to Progress Notes (Tenant #3's notes) dated 4-27-11, it was reported by another tenant that on 4-26-11, Tenant #3 grabbed Tenant #7 around the neck, shook the tenant twice and let the tenant go when the other tenant screamed. The notes indicated it was not witnessed by staff. Once reported to staff, a nurse review was not completed to assess the tenant for any possible injuries or outcomes related to the incident. Nurse review was not completed as needed.

  - Regulatory Insufficiency: If a tenant does not receive personal or health related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation:

To ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program. (IAC r. 481-69.27(2))

- Regulatory Insufficiency: If a tenant does not receive personal or health related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 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))

F. Other

Complaint Allegation: It was alleged tenants were supposed to receive whirlpools and the whirlpool did not function. It was alleged tenants did not receive appropriate bathing services because the whirlpool was broken.

- Monitoring Observation: Maintenance Logs were reviewed and an entry on 12-17-10 indicated the whirlpool was broken and was a hazard. At the time of the investigation the whirlpool did not function.

  Staff #1 stated the whirlpool had not worked in a long time. Staff #2 stated the whirlpool had not worked for close to a year. Staff #3 stated the whirlpool had not worked since September.

  The Admission Agreement indicated assistance with bathing, with a standard of two baths per week was available.

  Tenant #1's file was reviewed. The preliminary service plan indicated the tenant received a whirlpool for bathing. A functional evaluation indicated the tenant did not like showers and needed assistance with a whirlpool.

  Tenant #2's file was reviewed. The preliminary service plan indicated the tenant received assistance with bathing. The functional evaluation indicated the tenant required assistance with a whirlpool and shampoo.

  Tenant #5's file was reviewed. The tenant's service plan indicated staff was to provide a physical assist with whirlpool bathing to ensure all the old cream and ointments and soap were removed to help the tenant not itch. The plan indicated to return to the whirlpool as soon as possible (service plan updated 2-14-11).

  The Director stated the whirlpool was broken when she was hired. She said there had been someone out to try to repair the whirlpool three to four times over the past couple of months.

- Regulatory Insufficiency: All tenants have the following rights: To receive care, treatment and services which are adequate and appropriate. (IAC r. 481-67.3(2))

Dated this 11th day of July, 2011.