IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 35116-C
Incident Intake #: 35149-I

September 14, 2011

Emily Elmendorf, Director
Bickford Senior Living
3500 Lower W. Branch Road
Iowa City, IA 52245

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

Dear Ms. Elmendorf:

I. Final Complaint & Incident Investigation Report – Bickford Senior Living, Iowa City, IA

Enclosed is the **Final Complaint & 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: Tenant Documents, Service Plan, Nurse Review, Dementia Specific Education for Program Personnel, Other (Tenant Rights). **Bickford Senior Living** ("Program") is being assessed a $5,000 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 three thousand two hundred fifty dollars ($3250) 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 $5,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on September 2, 2011, has been reviewed and will constitute the final POC related to the on-site visit of August 2 & 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, 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 & Incident Investigation Report

Assisted Living Program:

Emily Elmendorf, Director
Bickford Senior Living
3500 Lower Branch Road
Iowa City, IA 52245

Complaint Intake #: 35116-C
Incident Intake #: 35149-I

Dates of Investigation:

August 2 & 3, 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 and on-site visit was conducted at Bickford Senior Living on August 2 & 3, 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):	9
Current number of tenants without cognitive disorder:	29
Total Population:	38

***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 May 25 and 26, 2011, resulted in a $4,000.00 civil penalty and regulatory insufficiencies in the following areas: Evaluation of Tenants, Service Plan, Nurse Review, Tenant Documents and Rights.

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.

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

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

A. Tenant Documents

During the investigation, the following information was obtained.

- Monitoring Observation: According to an internal investigation record and the Program's self-report, an allegation of abuse was made on 7-22-11 regarding Tenant #1 and involved Staff #2, #3, #4 and the RN Coordinator.

Tenant #1 (the Tenant), an 85 year old, was admitted on 5-16-11 and diagnoses include: Dementia, Urinary Obstruction, Delirium, Urinary Tract Infection (UTI) (Lower UTI), Syncope and Collapse. The Tenant was staged a six on the Global Deterioration Scale, which indicated severe cognitive decline.

According to the Program's self-report, following failed interventions from the previous evening and overnight shift and conversations with the Tenant's family, the RN Coordinator, Staff #2, #3 and #4 went to the Tenant's apartment to clean up the Tenant and get the Tenant out of a soiled brief. Staff #1 reported that the RN Coordinator and Staff #3 grabbed the Tenant's arms and held them up while the Tenant sat in his/her chair. Staff #1 reported Staff #2 attempted to apply deodorant and the Tenant yanked his/her arm away. Staff #1 reported the RN Coordinator and Staff #3 took the Tenant by the underarms and the back of the pants and lifted the Tenant up. The Tenant continued to fight against the staff. Staff #1 got a wheelchair for the Tenant. Staff #1 did not like what she had seen and left the room.

According to an internal investigation record, Staff #2, #3, #4 and the RN Coordinator were placed on suspension pending further investigation. On 7-25-11, the Director and the Divisional Director of Operations met with each person alleged in the incident as well as Staff #1. An internal investigation was completed. The Program came to the determination that abuse did not occur. The staff members alleged in the incident returned to work on 7-28-11. The staff members alleged in the incident was scheduled to have no contact with Tenant #1 pending the outcome of the Department's investigation.

An incident report was not completed related to allegation of abuse.

- 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))

B. Service Plan

During the investigation, the following information was obtained.

- Monitoring Observation: Tenant #1's file was reviewed. The service plan indicated (under Bathing) total assistance needed and assistance of staff needed and encourage the Tenant to bathe. The service plan indicated (under Toileting) the Tenant needed assistance with pants and undergarments. Give privacy in bathroom and the Tenant needed daily assistance with toileting and peri-care. The service plan indicated (under Health Monitoring) Hospice services were added. The service plan indicated (under Catheter) the Tenant had a foley catheter and the doctor changed monthly in the office due to Tenant anxiety. Progress Notes from 5-29-11 to 7-29-11 indicated the Tenant refused cares at times and was combative at times regarding refusal of cares. The service plan did not reflect refusal of cares, combative behavior or interventions. The service plan did not address who provided assistance with the Tenant's catheter besides the monthly change in the doctor's office. Hospice was added to the service plan; however, specific services that Hospice provided were not

indicated on the service plan. The service plan was not individualized and did not indicate the Tenant's identified needs and preferences for assistance.

- 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. Nurse Review

During the investigation the following information was obtained.

- Monitoring Observation: According to an internal investigation record and the Program's self-report, an allegation of abuse was made on 7-22-11 regarding Tenant #1 and involved Staff #2, #3, #4 and the RN Coordinator.

  According to the Program's self-report, following failed interventions from the previous evening and overnight shift and conversations with the Tenant's family, the RN Coordinator, Staff #2, #3 and #4 went to the Tenant's apartment to clean up the Tenant and get the Tenant out of a soiled brief. Staff #1 reported that the RN Coordinator and Staff #3 grabbed the Tenant's arms and held them up while the Tenant sat in his/her chair. Staff #1 reported Staff #2 attempted to apply deodorant and the Tenant yanked his/her arm away. Staff #1 reported the RN Coordinator and Staff #3 took the Tenant by the underarms and the back of the pants and lifted the Tenant up. The Tenant continued to fight against the staff. Staff #1 got a wheelchair for the Tenant. Staff #1 did not like what she had seen and left the room.

  According to an internal investigation record, Staff #2, #3, #4 and the RN Coordinator was placed on suspension pending further investigation. On 7-25-11, the Director and the Divisional Director of Operations met with each person alleged in the incident as well as Staff #1. An internal investigation was completed. The Program came to the determination that abuse did not occur. The staff members alleged in the incident returned to work on 7-28-11. The staff members alleged in the incident was scheduled to have no contact with Tenant #1 pending the outcome of the Department's investigation.

  A nurse review was not completed related to the allegation of abuse and to assess the Tenant for any possible injuries or change in health status. 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 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))

D. Dementia-Specific Education for Program Personnel

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

- Monitoring Observation: Five staff files were reviewed regarding dementia-specific training. Staff #3 was hired on 12-10-10 and did not have eight hours of dementia-specific education within 30 days of employment. The RN Coordinator was hired on 5-11-11 and did not have eight hours of dementia-specific education within 30 days of employment.

- Regulatory Insufficiency: All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. (IAC r. 481-69.30(1))

E. Other

Complaint Allegation #35116-C: It was alleged a tenant was not treated appropriately when the tenant refused assistance from staff with personal cares.

Incident Allegation #35149-I: The Program self-reported an allegation of abuse was made on 7-22-11 regarding a tenant and four staff members. The Program reported following failed interventions from the previous evening and overnight shift and conversations with a tenant's family, four staff went to a tenant's apartment to clean up the tenant and get the tenant out of a soiled brief. It was reported staff yanked the tenant's arms and lifted the tenant by the arms and pants. It was reported the tenant resisted the cares during the process and staff continued to provide cares.

- Monitoring Observation: Three tenant files were reviewed. Tenant #1's file indicated the Tenant refused cares at times and was combative at times regarding refusal of cares.

  Staff #1 was interviewed and provided a written statement. She stated at 7:20 a.m. she was instructed per the RN Coordinator to give the Tenant scheduled Ativan .5mg and also Ativan .5 mg, which equaled 1 mg Ativan. Upon giving medication, then Staff #2, #3, #4 and the RN Coordinator entered the room and stated they were going to clean up the Tenant. Staff #3 and the RN Coordinator grabbed the Tenant's arms up to take off his/her shirt. The Tenant was swinging and told staff to get away from him/her. Staff #2 tried to put deodorant on the Tenant and the deodorant dropped on the floor. Staff #4 tried to pick up the deodorant and the Tenant began to kick. Staff #2 stated to get the Tenant in the shower. Staff #3 and the RN Coordinator took the Tenant underarms and by the back of the pants and lifted the Tenant up. The Tenant fought against them. She was afraid of the Tenant falling and offered a wheelchair. The Tenant was assisted to the wheelchair. She did not like what she had seen and left the room. She stated there was no restraint or gait belt used to restrict the Tenant's movement. She assessed the Tenant later that day and did not see anything new; however, the Tenant was hard to assess.

  The RN Coordinator was interviewed and provided a written statement. She indicated on 7-21-11 at 6:04 p.m. she received a call that the Tenant's brief was

soiled with stool and he/she refused to change it. The Tenant's family had also tried to get him/her to change without success. She called the Program at 9:07 p.m. and was told staff was still not able to get the Tenant changed. The RN Coordinator, staff and family agreed to try to clean the Tenant up the next morning. She made the decision to wait until morning since the Tenant was already agitated. She called at 6:43 a.m. on 7-22-11 and was told the Tenant did not sleep well and remained resistant to attempts to suggest he/she change. She arrived at 7:10 a.m. She asked Staff #1 to give scheduled dose of Ativan plus a PRN dose of Ativan. She indicated that was done prior to physician appointments to calm the Tenant. She said the Tenant received the low end of the PRN dose of .5 mg and the scheduled dose of .5 mg for a total of 1 mg. Physician orders indicated at the time of the incident the Tenant was prescribed Ativan .5mg take one to two tablets (.5 mg to 1 mg) by mouth every eight hours as needed and Ativan .5 mg twice daily at breakfast and 3:00 p.m. She went to the Tenant's apartment and the spouse reported the Tenant still refused. She made several attempts in the 5-10 minutes and the attempts were unsuccessful. She left the apartment and spoke with the Tenant's spouse about the plan to get the Tenant changed. She returned to the apartment with Staff #2, #3 and #4. Staff #1 was in the apartment by the Tenant attempting to get him/her to take the medication. Staff #1 told her the Tenant had taken the liquid Ativan and she was trying to get him/her to take the remainder of the medications. They stood in the back of the apartment and waited for the Tenant to take the medication. Staff #1 was not successful in her attempts to get the Tenant to take the other medications and it was agreed she would try later. Staff #1 and the Tenant's spouse left the apartment. One of the other staff and the RN Coordinator removed the Tenant's shirt and assisted the Tenant to a standing position to remove the rest of the clothing except the undergarment. During that time the Tenant attempted to push staff away with a balled fist, made attempts to bite staffs' arms and swore at staff. The Tenant was told they were not going to hurt him/her and the Tenant's spouse wanted them to help him/her. The Tenant was not restrained in any manner but at times staff did hold his arm or hand loosely to prevent him/her from injuring staff or pulling on his/her catheter. It was decided to shower the Tenant rather than a sponge bath. The Tenant was placed in a wheelchair and taken to the entrance of the bathroom. Two staff stood in the bathroom and assisted the Tenant out of the chair to a standing position. Two staff transferred the Tenant into the shower. Following the shower the Tenant was assisted to his/her feet and was dried off. Staff #4 applied petroleum jelly to the Tenant's reddened peri area. The Tenant was seated in the wheelchair and was dried more thoroughly, catheter straps were changed and the Tenant was dressed. The bath did not begin until at least 7:25 a.m. and she was back in the dining room to help with breakfast at 7:45 a.m. All staff that worked with the Tenant spoke soothingly to the Tenant and provided reassurance. There was no force used throughout the process and no restraints were used at any time. The Tenant had an indwelling foley catheter, a history of infections and a soiled brief.

Staff #2 was interviewed and provided a written statement. She stated she came into work on 7-21-11 and noticed a note in the communication book that indicated the RN Coordinator would be in at 7:00 a.m. to give Ativan to the Tenant and to assist with cleaning up the Tenant. The following morning on 7-22-11 Staff #1, #2, #3, #4 and the RN Coordinator headed towards the Tenant's apartment to assist with medications and clean up. Staff #1 was the first one in the Tenant's apartment and finished giving the medications. The Tenant was informed that he/she was soiled and they were there

to help clean him/her up. Staff #2 began to make soapy water while Staff #3 and the RN Coordinator took his/her tee shirt off. The Tenant was stood up by two staff who tried to pull down the Tenant's pants. The Tenant became verbally and physically abusive. They explained they were there to help the Tenant not hurt the Tenant. The Tenant's gait was unsteady and someone grabbed a wheelchair. Staff #2 and #3 placed their arms underneath his arms while the RN Coordinator and Staff #4 finished undressing the Tenant. Once the pants were down and they noticed how soiled the Tenant was Staff #2 suggested a shower and everyone agreed. The RN Coordinator said only if the Tenant or staff did not get hurt. The Tenant was wheeled into the bathroom and Tenant held the bar and stood while staff washed him/her. The Tenant started tugging on the shower hose. Staff #3 rinsed the Tenant off and he/she took a dry towel and began to dry himself/herself off. Staff #4 and the RN Coordinator finished drying. Staff #3 and the RN Coordinator assisted with dressing. The Tenant and the Tenant's spouse were very happy. She said staff did not use force or restraints and there was no harm to the Tenant. She stated the Tenant's dignity was upheld.

Staff #3 was interviewed and provided a written statement. She stated she was asked the RN Coordinator to help assist with a shower for the Tenant. The Tenant had a bowel movement and refused to let his/her spouse, family or staff clean him/her up. Staff #1 gave the Tenant medications to calm him/her down and staff prepared for the Tenant's shower. Staff assisted taking off his/her top with no problem and got the Tenant to a standing position to take down his/her pants and assisted with sitting the Tenant in the wheelchair. The Tenant resisted a little but once the pants were off the Tenant was okay. The Tenant walked into the shower with one assist and grabbed the hand rail in the shower. The Tenant called staff names when the water was on and once the Tenant was rinsed he/she was fine. The Tenant helped assist with drying off. Staff got the Tenant dressed and he/she was happy. She stated that no restraints were used and staff was not forceful with the Tenant. She said the Tenant did not cry at any time and she did not feel there were any issues with tenant rights. She indicated everyone was safe and unharmed.

Staff #4 was interviewed and provided a written statement. She was informed that the Tenant needed a shower but the Tenant needed to get Ativan. Staff #2, #3, #4 and the RN Coordinator walked down together and Staff #1 was in the room administering the Tenant's medications. Staff #1 got a wheelchair for the Tenant to sit in. Staff #4 put deodorant on the Tenant's left arm and he/she started swinging so the RN Coordinator grabbed the Tenant's arm so he/she would not make contact. She said his/her arm was not held down but it was so the Tenant would not make contact. She said there was no harm to the Tenant. Staff took off the Tenant's undershirt and Staff #2 and the RN Coordinator stood the Tenant up to get the Tenant's pants off. Staff #4 could only get them half way off and Staff #3 got them off. Staff #2 and #3 got the Tenant to the shower chair. They showered the Tenant and he/she called them names. The Tenant dried off his/her arms and she asked to dry the Tenant's legs. She put petroleum jelly on his/her buttocks. She cleaned up the bathroom and when she got done the Tenant was dressed. She put on one shoe and the RN Coordinator put on the other. She said staff did not use force or restraints. Staff wanted to make sure he/she was clean and he/she needed to be cleaned because he/she had quite a bit of BM in the brief. She stated the Tenant did not understand the process and it was

hard to explain to someone with dementia. She said staff was respectful during process and wanted to make sure he/she was clean.

The Tenant's family member was interviewed. The Tenant's family was informed of the incident and did not have any concerns with the situation.

The Tenant received .5 mg of scheduled Ativan and .5mg of PRN Ativan on 7-22-11; however, the cares were attempted shortly after administration of the medication. There was four staff that approached the Tenant and provided care to a Tenant with severe cognitive decline. The Tenant did not receive care, treatment or services which were adequate and appropriate.

- 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 14th day of September, 2011.