IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

**DEMAND LETTER**
**CERTIFIED**
**Incident Intake #: 33682-IR-1**

September 20, 2011

Annette Grochala, Administrator
Bickford of Urbandale
5915 Sutton Place
Urbandale, IA 50372

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

Dear Ms. Grochala:

**I. Final Incident Investigation Revisit Report – Bickford of Urbandale, Urbandale, IA**

Enclosed is the **Final Incident Investigation Revisit 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: Food Service, Staffing, Dementia Specific Education for Program Personnel and Monitoring, Plans of Correction and Requests for Reconsideration. **Bickford of Urbandale** ("Program") is being assessed a $500 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 hundred twenty five dollars ($325) 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 $500 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on September 14, 2011, has been reviewed and will constitute the final POC related to the on-site visit of August 24 and 25, 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 Incident Investigation Revisit Report

**Assisted Living Program:** **Incident Intake #: 33682-IR-1**

Annette Grochala, Administrator
Bickford of Urbandale
5915 Sutton Place
Urbandale, IA 50372

**Date of Monitoring Visit:**

August 24 and 25, 2011

**Monitor(s):**

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 a Recertification Monitoring Evaluation 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 incident investigation revisit was conducted at Bickford of Urbandale on August 24 and 25, 2011. In preparing this report, the following information was considered:

***Dementia Specific Program (DSP)**** – A program that is a Dementia Specific Program by definition but may have tenants without cognitive disorder.

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|---|---|
| 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: | 18 |
| Total Population: | 27 |

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

| | |
|---|---|
| Total Population of DSP: | 7 |
| **Total Census of ALP:** | 34 |

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

**Program History** –The program received regulatory insufficiencies during the Nov 15, 2010 Recertification and Incident Investigation (33684-I) in the areas of Nurse Review and Staffing.

During the May 18 and 19, 2011 Incident Investigation (33682-I) the program received regulatory insufficiencies in the areas of: Occupancy Agreement, Evaluation, Food Service, Staffing, Dementia Specific Education, Record Checks, Notification to the Dept. and Policy and Procedure.

During the June 27, 2011, Incident Investigation (34469-I, 34722-I) the program received regulatory insufficiencies in the areas of: Policy and Procedure, Evaluation and Service Plan.

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

**A. Occupancy Agreement**

The Program received a regulatory insufficiency at the time of the May 2011 onsite incident investigation related to failure of the signed occupancy agreements to contain language as required by regulations updated January 2010 for Tenant #2, #3, and #5.

Monitoring Observation: Tenant #2 and Tenant #5 left the Program in May 2011. The occupancy agreement for Tenant #3 was reviewed. An agreement and addendum with a document date of 11/10 was signed by the Tenant's legal representative on 6-20-11.

Additional occupancy agreements were reviewed for tenants that resided at the Program. Three occupancy agreements and addendums with a document date of 11/10 were found to be signed by the tenant or legal representative prior to 7-1-11.

- Regulatory Insufficiency: None noted.

**B. Evaluation of Tenant**

The Program received regulatory insufficiencies related to failure to evaluate tenants' functional, cognitive and health status prior to and within 30 days of occupancy, or with significant change. Tenants #1 was identified as not having a health evaluation completed prior to admission, #3, was identified as not having a cognitive evaluation completed with a service plan update, and #4 was identified as not having a cognitive evaluation completed at 30 days or evaluations completed with change of condition.

Monitoring Observation: Tenant #4 transferred out of the Program in April 2011 and did not return prior to moving out in August 2011. The clinical record was not reviewed.

The Program noted contract licensed staff were used to complete the evaluations originally cited. The Program has had its own registered nurse since 5-3-11.

Tenant #1 had evaluations completed on 5-6-11. Evaluations were also completed on 7-11-11 with a transfer to the dementia unit. Tenant #3 had evaluations completed on 5-23-11. Evaluations were also completed on 7-5-11 with a change of condition.

One additional chart was reviewed for a tenant admitted 7-15-11. Evaluations were completed prior to and within 30 days of admission.

- Regulatory Insufficiency: None noted.

**C. Nurse Review**

The Program received a regulatory insufficiency related to failure to complete a nurse review following a fall and with changes in condition. Tenant #3 and #4 were identified.

Monitoring Observation: Tenant #3 had a nurse review completed on 7-5-11 with a change of condition. Tenant #4 transferred out of the Program in April 2011 and did not return prior to moving out in August 2011. The clinical record was not reviewed.

One additional chart was reviewed with no concerns of completion of a nurse review.

- Regulatory Insufficiency: None noted.

**D. Food Service**

The Program received a regulatory insufficiency for failure to provide documentation of an inservice on sanitation and safe food handling. Staff #3 and #4 were identified.

Monitoring Observation: Staff #3 received food safety and sanitation training on 6-17-11. Staff #4 was no longer employed at the Program.

Staff # 11 was hired 7-11-11 as a Certified Nursing Assistant (CNA). The Program did not provide documentation of food safety training. Staff #12 was hired 7-9-11. The

documentation of the food safety and sanitation was not dated and was not signed by the person doing the training.

- Regulatory Insufficiency: Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. (IAC r. 481-69.28(5))

**E. Staffing**

The Program had reported a tenant had eloped from the secure dementia unit. The Program received a regulatory insufficiency for failure to provide documentation of staff training on the alarm system and failure of the Program to hold a Missing Resident/Unwitnessed Door Alarm drill. Staff #3, #4, #5, #6, and #7 were identified.

Monitoring Observation: Staff #3 had alarm system training on 6-17-11. Staff #7 had documentation of alarm system training, but the form was not dated. Staff #4, #5, and #6 were no longer employed at the Program. A Missing Resident/Unwitnessed Door Alarm drill was held on 6-9-11. The Program provided documentation of a weekly inspection of the alarm system.

Staff #12 was hired 7-9-11 as a CNA. The Program did not provide documentation of alarm system training.

- Regulatory Insufficiency: The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population. (IAC r. 481-69.29(3))

The Program received a regulatory insufficiency for failure to provide documentation of Registered Nurse (RN) delegations for activities of daily living or special skills such as indwelling catheter care. Staff #3, #4, and #5 were identified.

Monitoring Observation: The Program currently has no tenants with indwelling catheters. Staff #3 had documentation of nurse delegation training on activities of daily living on 6-6-11. Staff #4 and #5 were no longer employed by the Program.

Three new employee files were reviewed. All contained documentation of nurse delegation training on activities of daily living within 30 days of employment.

Two staff, employed as CNA's, were interviewed. Both stated the RN observed them providing cares.

- Regulatory Insufficiency: None noted.

**F. Dementia-specific education for program personnel**

The Program received a regulatory insufficiency for failure to provide documentation of eight hours of dementia training within 30 days of employment. Staff #3 and #4 were identified.

Monitoring Observation: Staff #3 completed eight hours of dementia training by 6-23-11. Staff #4 was no longer employed by the program.

Staff #11 was hired 7-11-11. The program did not provide documentation of eight hours of dementia training within 30 days of employment.

Staff #12 was hired 7-9-11. Staff #13 was hired 6-27-11. Both staff had six hours of dementia training documented within the first 30 days of employment. On 8-24-11 employee files did not contain documentation of an additional two hours of dementia training. The Divisional RN revealed the two hours of training was a case study regarding a tenant at the program, and Staff #12 and #13 would be working the evening shift. When this monitor arrived on 8-25-11, the program provided documentation of the additional two hours for both employees dated 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))

**G. Record Checks**

The Program received a regulatory insufficiency for failure to provide documentation of a dependent adult abuse check on Staff #3, and failure to provide documentation of a criminal history, dependent adult abuse or child abuse check on Staff #4.

Monitoring Observation: Staff #3 had documentation of all background checks completed on 5-19-11. Staff #4 was no longer employed by the Program.

Three new employee files were reviewed. All files reviewed contained documentation of background checks completed prior to employment.

- Regulatory Insufficiency: None noted.

**H. Program Notification to the Department**

The Program received a regulatory insufficiency for failure to notify the Department within 24 hours after an elopement. Tenant #1 was identified.

Monitoring Observation: The chart for Tenant #1 was reviewed. The chart contained no documentation of any other elopement attempts. The Tenant was transferred to the dementia unit on 7-5-11. Administration reported no further attempts at elopement since the May 2011 onsite visit. The Program provided documentation of training as outlined

in the Plan of Correction. Incident reports dated July 1, 2011 to current were reviewed with no documentation of any elopements noted.

- Regulatory Insufficiency: None noted.

## I. Program Policies and Procedures

The Program received a regulatory insufficiency for the lack completion and signature on an incident report by a staff person in charge at the time of the incident. Also, the Program did not follow its policy on documentation of Missing Resident/Unwittnessed Door Alarm Drills.

Monitoring Observation: The Program provided documentation of a Missing Resident/Unwitnessed Door Alarm Drill. The drill was documented on the appropriate form. The Program provided documentation of the designation of a person in charge on each shift. Two staff persons indicated they knew how to tell who was in charge, and were able to tell this monitor who was in charge at the time. The Program provided documentation of staff training on use of pagers and completion of incident reports.

- Regulatory Insufficiency: None noted.

## J. Monitoring, Plans of Correction and Requests for Reconsideration

Monitoring Observation: The program failed to follow the Plan of Correction, (POC) submitted to the Department on June 14, 2011, in the areas of: Food Service, Dementia Specific Education and partially failed to follow the POC in the area of Staffing.

- Regulatory Insufficiency: The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance. IAC r. 481-67.10(8)

Dated this 20th day of September, 2011.