IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 36271-C

December 23, 2011

Ms. Angie Cozadd, Director
Bickford Cottage Burlington
3301 Sterling Drive
Burlington, IA 52601

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

Dear Ms. Cozadd:

I. Final Complaint/Incident Investigation Report – Bickford Cottage Burlington, Burlington, 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: Staffing, Criteria for Exclusion of Tenants and Structural Requirements. **Bickford Cottage Burlington** ("Program") is being assessed a $1,000 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 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 pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on December 15, 2011, has been reviewed and will constitute the final POC related to the on-site visit of November 8 & 9, 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:

Angie Cozadd, Director
Bickford Cottage Burlington
3301 Sterling Drive
Burlington, Iowa 52601

Complaint/Incident Intake #:

36271-C

Date of Complaint/Incident Investigation:

November 8 and 9, 2011

Monitor(s):

Maribeth Freland RN
Joyce Kix RN

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. 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.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	39
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	39
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	4
TOTAL census of Assisted Living Program	43

Program History – There were regulatory insufficiencies during this certification period in the area of Service Plans.

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

A. Medications

Complaint/Incident Allegation: It was alleged staff members administered medication unnecessarily to tenants when medications were ordered on an as needed basis for behaviors.

- Monitoring Observation: Tenant #3 (the Tenant), a 92 year old, was admitted on 10-7-08, currently resided in the program's dedicated memory care unit and had documented diagnoses of Progressive Alzheimer's type Dementia, Glaucoma and Hypertension (HTN). The Tenant scored at a 6 on the 11-3-11 Global Deterioration Scale (GDS), indicating severe cognitive decline. The nurse obtained an order for Xanax, an antianxiety medication, on 8-20-10. The Xanax was ordered to be administered on an as needed basis for anxiety or aggression. Staff members did not administer the Xanax during August or September 2010.

  On 10-10-10, Staff #4, Certified Medication Aide (CMA), documented the Tenant had been anxious and agitated. Staff members were unable to decrease the agitation with redirection. Staff #4 documented administering the Xanax with the medication being effective with symptom relief. On 10-29-10 Staff #11, CMA, documented the Tenant had been anxious and agitated with staff members. Staff members were unable to decrease the agitation with redirection. Staff #11 documented administering the Xanax with the medication not being effective for symptom relief.

Staff #10 later administered the Xanax again due to continued anxiousness and agitation with effectiveness of symptom relief following the second dose.

Tenant #9 (the Tenant), an 80 year old, was admitted on 11-17-10, died on 4-9-11 and had documented diagnoses of Alzheimer's Dementia with Hallucinations and Delusions, Adult Failure to Thrive, Coronary Artery Disease and HTN . The Tenant scored at a 4 on the 11-24-10 GDS, which indicated moderate cognitive decline. The Tenant was scored at a 7 on the 3-19-11 GDS, which indicated very severe cognitive decline. Tenant #9 previously resided in the program's dedicated memory care unit.

Three days prior to the Tenant's admission into the program, he/she was hospitalized after exhibiting behavior changes, extreme agitation and multiple attempts to leave his/her home unattended. The Tenant was subsequently admitted at the assisted living.

According to the evaluation and corresponding service plan, dated 11-16-10, the Tenant was independent with eating, transferring, ambulation, toileting, grooming and dressing. The Tenant required staff member assistance for bathing and medication administration.

Progress notes documented the Tenant was admitted on 11-17-10. Within several hours of the Tenants arrival he/she began pacing the memory care unit, showing anxiety and agitation. The Tenant began expressing a wish to leave the unit and threw personal items at the windows. Staff members were unable to successfully redirect the Tenant, requiring administration of Risperidone, an antipsychotic medication. The Tenant's behavior continued into the evening, requiring administration of Trazodone, an antidepressant medication at 9:30 PM. The Tenant's behavior continued despite medication administration, resulting in the Tenant's transfer to the emergency room for psychiatric evaluation.

Tenant #9 returned to the program in the early morning hours of 11-18-10 without admission to the hospital. The Tenant was calm and immediately fell asleep. Emergency room discharge orders documented the physician's direction to give the Tenant Risperidone and Trazodone on a routine basis the following day to assist with behaviors and agitation. The staff members gave the Risperidone and Trazodone according to the emergency room physician's direction. The Tenant exhibited no behaviors on 11-18-10.

On 11-19-10, the Tenant began to express hallucinations and delusions without behaviors noted. During the late afternoon/evening hours the Tenant began experiencing agitation, attempting to exit seek and was attempting to toilet in the outdoor courtyard. Staff members administered the Risperidone and Trazodone on an as needed basis with effective results.

On 11-20-10, the Tenant expressed hallucinations and delusions throughout the day. Was up all day and most of night. Staff members administered the Risperidone and Trazodone on an as needed basis with effective results.

On 11-21-10, the Tenant slept most of day and night, thereby not requiring administration of the as needed medications.

On 11-22-10, the Tenant again exhibited increased agitation and behaviors in the late afternoon/evening requiring administration of the Risperidone and Trazodone. The nurse contacted the physician to obtain an order for a scheduled dose of Risperidone and Trazodone as well as an as needed dosage of both medications. The Tenant's behaviors and agitation decreased with the initiation of the scheduled dosage of both medications.

The medications administered to Tenant #3 and Tenant #9 was necessary to decrease behaviors and agitation when redirection was not successful.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation: It was alleged the program did not routinely assure tenants residing in the dedicated memory care unit were adequately supervised, resulting in multiple tenant falls, some resulting in injury or death. It was alleged program staff members did not assure tenant safety when assisting with mobility and toileting. It was alleged staff members had to call in tenant families to assist with care as the staff members were unable to get care completed and unable to assure other tenants safety in a reasonable manner.

- Monitoring Observation: The monitors spoke with the families of Tenants #2, #4 and #5. All three of the tenant's families denied being called in to care for their loved one to assure safety due to staff members being too busy caring for other tenants.

  Tenant #2's family member reported concerns that when visiting he/she often observed Tenant #1, another confused tenant residing in the memory care unit, attempting to help other tenants out of recliners and had to intervene as no staff were available in the immediate area.

  Tenant #4's family member reported concerns that when visiting he/she often found staff members to be absent from the common area where several tenants were gathered for 30 minutes or longer. The family member reported observing Tenant #1, another confused tenant residing in the memory care unit, attempting to assist Tenant #4 and Tenant #5 up from the recliners and had to intervene to keep each tenant from falling as neither could walk independently.

  Tenant #5's family member reported concerns that when visiting he/she often found multiple tenants left unattended in the common area of the memory care unit for extended periods of time. He/she reported being called by staff members on one occasion as Tenant #1 assisted Tenant #5 up from the recliner, causing Tenant #5 to fall. The family member reported on October 9, 2010, he/she arrived at the program and found Tenant #5 in the common living room area with his/her pants pulled down. It appeared he/she had toileted self and ambulated to the living area but had been unable to pull his/her pants back up. Tenant #5 required assistance with toileting, ambulation and dressing at the time. (The clinical record lacked any documentation regarding this incident.) The family member reported Staff #11, CMA, allowed Tenant #5 to ambulate independently resulting in a fall without injury on 12-25-10.

(According to the incident report, dated 12-25-10, Staff #8, CMA, found Tenant #5 in his/her room on the floor in the bathroom. No injury was noted. Tenant #5 did not use a pad alarm at that time.)

The monitors noted email correspondence, dated 3-29-11, in the financial file of Tenant #9. The correspondence between Tenant #9's family member and the Director of the program documented the family member's concern with tenants being left unsupervised in the common area of the memory care unit. The family member reported visiting on 3-29-11. Upon arrival into the memory care unit, the family member saw no staff in the immediate area. The family member reported Tenant #3 had a bowel movement and had removed the stool from his/her pants with his/her hands. Tenant #11 was walking around the common area with no underwear or pants on. The family member noted the direct care staff member in charge of the memory care unit was in Tenant #5's room assisting with toileting. A staff member from the general population area entered the memory care unit several minutes after the family member found this situation and assisted the tenants.

The monitors reviewed the clinical records of the following tenants:

Tenant #1 (the Tenant), a 63 year old, was admitted on 4-9-11, currently resided in the program's dedicated dementia unit and had a documented diagnosis of Pick's Disease Dementia. The Tenant scored at a 4 on the 8-18-11 (GDS), which indicated moderate cognitive decline. The Tenant moved into the memory care unit on 8-18-11 due to an increased wandering into other tenants' rooms without successful redirection while living in the general population area. The Tenant appeared to no longer understand or speak words. He/she began using gestures and understood only gestures when used by staff members.

According to the evaluation and corresponding service plan, dated 8-18-11, the Tenant was independent with eating, transfers, toileting and ambulation. The Tenant required assistance with bathing, grooming, dressing and medication administration.

According to the Progress Note, dated 8-24-11, the Tenant had been more anxious and less cooperative in the few previous days. He/she had urinated in an inappropriate place on one occasion. Lorazepam, an antianxiety medication was initiated as needed for anxiety. Progress notes documented no further incidents of anxious or inappropriate behaviors noted by staff members following the initiation of Lorazepam.

According to the incident report, dated 8-29-11, Tenant #5, another tenant residing in the memory care unit, fell while unattended by staff members in the common living room area. Tenant #5 told Staff #11, CMA, that Tenant #1 had pulled him/her out of a recliner. Tenant #5 required the assistance of one staff member to transfer and ambulate. Tenant #5 was not injured.

According to the incident report, dated 10-6-11, Tenant #1 slapped Staff #10, CMA, while the staff member attempted to redirect the Tenant.

Staff #1, CMA, reported Tenant #1 did on occasion attempt to help other tenants out of recliners or the couch in the common living room when staff members were in other tenant rooms assisting individual tenants.

Staff #2, Certified Nurse Aide (CNA), reported Tenant #1 often attempted to assist tenants up out of recliners and the couch in the common living room when staff members were in other tenant rooms assisting individual tenants. Staff #2 reported Tenant #5 once fell due to Tenant #1 assisting him/her out of the recliner. Staff #2 reported feeling one staff member working in the memory care unit was not enough in the past as multiple tenants required a lot of assistance with personal care tasks.

Staff #3, Licensed Practical Nurse (LPN), reported Tenant #1 ambulated independently and was often difficult to redirect. She reported other staff members previously reported Tenant #1 attempted to help other tenants out of the recliners and couch located in the common living room area of the memory care unit. The LPN expressed concerns that staff members struggle to get tasks completed and provide appropriate supervision of the other tenants when tied up caring for an individual in his/her room.

Staff #4, CMA, reported observing Tenant #1 reach out to assist another tenant out of his/her recliner; however, Staff #4 was able to intervene and Tenant #1 was easily redirected. Staff #4 reported knowledge that Tenant #5's family member had requested he/she not be left alone in the common area due to safety concerns with Tenant #1.

Staff #6, a former direct care worker, reported having concerns with staffing issues in the memory care unit. He/she reported telling the Director more staff coverage was required with no changes occurring. Staff #6 reported multiple tenants resided in the unit that took extended periods of time to care for, leaving other tenants left unattended.

Staff #11, CMA, reported concerns with the staff coverage in the memory care unit, expressing safety of tenants left unattended as the cause for concern.

Tenant #5 (the Tenant), an 88 year old, was admitted on 6-24-10, previously resided in the program's dedicated memory care unit, moved out of the program on 11-5-11 and had documented diagnoses of Dementia, Sciatica and Scoliosis. The Tenant scored at a 4 on the 9-7-11 GDS, which indicated a moderate cognitive decline.

According to the evaluation and corresponding service plan, dated 9-7-11, the Tenant required the assistance of one staff member to cut up food during meals, bathing, grooming, dressing, transfers, ambulation with a walker and one staff person and toileting. The Tenant used a pad alarm at all times when in bed or chair to alert staff members to the Tenant's rising should he/she attempt independently.

According to the incident report, dated 8-7-11, Staff #7, CMA, found the Tenant on the floor in front of a recliner located in the common living room. No witnesses were identified on the report and mention of the alarm sounding was not documented. The Tenant had a bruise noted to his/her forehead, chin and right knee. The Tenant appeared to be more agitated than usual.

According to the incident report, dated 8-9-11, Staff #3, LPN, was preparing to assist the Tenant with showering when the Tenant stood independently, falling backwards and hit his/her head causing a half inch laceration to the back of the head.

According to the incident report, dated 8-28-11, the Tenant's family member was assisting the Tenant with transferring when the Tenant's legs gave out and he/she fell, striking his/her head on a coffee table with no injury.

According to the incident report, dated 8-29-11, Staff #11, CMA, found the Tenant on the floor in the common living room of the memory care unit. Tenant #5 told Staff #11 that Tenant #1, another tenant residing in the memory care unit, had helped him/her up from the recliner. No injury was noted.

Tenant #6 (the Tenant), a 90 year old, was admitted on 2-26-09, died on 8-26-11 and had a documented diagnosis of Alzheimer's Dementia. The Tenant scored at a 5 on the 8-10-11 GDS, which indicated moderately severe cognitive decline and previously resided in the program's dedicated memory care unit.

According to the evaluation and corresponding service plan, dated 8-10-11, the Tenant was independent with eating, transfers and ambulation. The Tenant required assistance with bathing, dressing, grooming and toileting.

The incident report, dated 8-21-11, indicated Staff #1, CMA, observed the Tenant leaving the dining room following supper. The Tenant lost his/her balance resulting in a fall. The Tenant was immediately sent to the emergency room for medical evaluation. The Tenant was subsequently admitted to the hospital with the diagnosis of hip fracture. While hospitalized, the Tenant experienced a heart attack, dying one day later. The Tenant was attended during the fall which resulted in the hip fracture and the reason for death was other than the hip fracture.

Tenant #7 (the Tenant), a 91 year old, was admitted on 5-28-00, died 11-15-10 and had documented diagnoses of Stroke, Dementia, HTN and End Stage Renal Disease. The Tenant was scored at a 4 on the 7-6-10 GDS, which indicated moderate cognitive decline and previously resided in the program's dedicated memory care unit. The Tenant was admitted to hospice on 7-7-10.

According to the evaluation and corresponding service plan, dated 7/6/10, the Tenant required assistance with transfers and ambulation with a walker from bed to toilet, bathing, dressing, grooming and toileting. The service plan indicated the Tenant used a wheelchair with staff member assistance for propelling the chair for all mobility outside of his/her apartment.

The incident report, dated 9-19-10, indicated Staff #5, CMA, had assisted the Tenant into his/her wheelchair and pushed the Tenant from his/her apartment to the dining room area for breakfast. Staff #5 had failed to attach the wheelchair leg rests to the chair prior to transporting the Tenant, which required the Tenant to dangle or drag his/her feet while being pushed. The Tenant's feet caught on a rubber threshold on the floor, causing the Tenant to lurch forward falling out of the wheelchair.

The Tenant landed face first on the floor, hitting his/her head, resulting in a laceration above the left eyebrow and bruising to the eye area and cheek area.

The Tenant fell during staff member assistance receiving injury due to Staff #5's failure to attach the leg rests onto the wheelchair.

Tenant #11 (the Tenant), an 88 year old, was admitted on 3-19-11, died 8-10-11 and had documented diagnoses of senile Dementia and diabetes. The Tenant was scored at a 5 on the 6-30-11 GDS, which indicated moderate severe cognitive decline. The Tenant later scored at a 7 on the 8-8-11 GDS, which indicated very severe cognitive decline and previously resided in the program's dedicated memory care unit. The Tenant was admitted to hospice services on 7-15-11.

According to the evaluation and corresponding service plan, dated 6-30-11, the Tenant had been requiring staff member assistance with eating, bathing, dressing, grooming, toileting, transferring and ambulation. Tenant #11 had previous isolated falls on 3-27-11 and 5-11-11. Incident reports documented Staff #7, CMA, found the Tenant on the floor in the main common area of the memory care unit on 6/10/11 and 6/27/11. The Tenant had fallen or rolled off of the sofa while the staff member left in charge of all tenants in the unit was in another tenant's room assisting with personal care. Tenant #11 stood, falling to the floor, on 7-3-11, while being assisted in the bathroom by Staff #10, CMA, and fell again on 7-7-11, while being assisted by Staff #4, CMA. Incident reports documented Staff #7, CMA, found the Tenant on the floor in front of the Tenant's recliner on 7-9-11, indicating no witness to the incident and Staff #4, CMA, found the Tenant on the floor in front of the Tenant's wheelchair on 7-14-11, indicating other confused tenants as the only witnesses to the incident.

On 7-14-11 the nurse added the use of a pad alarm when up in a chair to alert staff to the Tenant's rising should the Tenant forget to call for help with transfers due to his/her cognitive issues. When the alarm was activated a message was sent to pagers carried by all direct care staff members.

Staff left the Tenant unsupervised on 6-10-11, 6-27-11, 7-9-11 and 7-14-11 despite his/her multiple previous falls, while assisted by staff members or while being unattended, during a short period of time and knowledge of the Tenant's propensity to stand unassisted despite his/her need for assistance. The nurse did not initiate an alarm system until the tenant had fallen six times in a one month period.

Tenant #12 (the Tenant), an 89 year old, had an admission date of 9-27-02, died on 12-30-10 and had documented diagnoses of Alzheimer's Dementia, Parkinson's Disease , HTN, Atrial Fibrillation and Arthritis. The Tenant scored at a 5 on the 10-25-10 GDS, indicating moderately severe cognitive decline and previously resided in the program's dedicated dementia units. The Tenant did not experience any falls prior to his/her death. He/she was admitted to hospice on 8-12-10 due to a declining condition. The Tenant died while under the care of hospice on 12-1-10.

On 11-8-11 the monitors observed Tenants #1 and #2 to be unattended in the common area of the memory care unit from 7:45 PM until 8:03 PM while Staff #1, CMA, assisted Tenant #3 in his/her room.

On 11-8-11 the monitors observed Tenants #1 and #3 to be unattended in the common area of the memory care unit from 8:05 PM to 8:17 PM while Staff #1, CMA, assisted Tenant #2 in his/her room. No other staff members were present in the memory care unit during this time.

On 11-9-11, Staff #9, RNC, reported the memory care average census in the previous three years had been routinely six to seven tenants each day.

The program routinely housed six to seven tenants in the memory care unit. During the past year, multiple tenants were housed who had been admitted to hospice, multiple tenants who required assistance with most personal care tasks and multiple tenants who experienced behaviors causing disruption to the other tenants residing in the unit. Multiple staff members reported concerns with staffing numbers in the unit, citing safety issues of unattended tenants as the major concern. Multiple family members expressed concerns related to safety issues when tenants were left unattended in the common areas of the unit. Multiple family members reported observations of tenants needs not being met when visiting the unit.

- 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))

C. Evaluation

Complaint/Incident Allegation: It was alleged the nurse did not complete tenant evaluations when changes in tenant conditions were identified. It was alleged multiple tenants experienced unexplained cuts or bruising. It was alleged multiple tenants experienced health concerns without appropriate timely follow up by a registered nurse.

- Monitoring Observation: Tenant #2 (the Tenant), a 91 year old, was admitted on 5-24-10, continued to reside in the program's dedicated memory care unit and had documented diagnoses of Dementia and Graves Disease. The Tenant scored at a 5 on the 10-7-11 GDS.

  According to incident reports, on 10-15-11 the Tenant was getting up from the dining room table with the assistance of Staff #7, CMA. During the transfer the Tenant lost his/her balance resulting a fall. The Tenant hit his/her head and back on the chair, leaving a red area on the back of the head and a bruise to the back. Staff #7 completed an incident report as required and notified the nurse who later assessed the injuries.

  Tenant #5's (the Tenant) clinical record indicated on 8-8-11 that the Tenant had exhibited increased agitation and anxiety over a period of 2 days. The nurse contacted the Tenant's physician to report the symptoms on 8-8-11. The physician ordered a urinalysis with culture and sensitivity on 8-8-11. Staff collected the urine sample on 8-8-11. Upon obtaining the results of the culture and sensitivity on 8-10-11, the physician ordered Keflex to treat the Tenant's bladder infection. Staff administered the first dose of Keflex on 8-10-11.

Tenant #8 (the Tenant), a 93 year old, was admitted on 3-15-07, died on 2-16-11 and had a documented diagnosis of dementia. The Tenant scored at a 6 on the 9-30-10 GDS, which indicated severe cognitive decline and previously resided in the program's dedicated memory care unit. The Tenant was admitted to hospice on 1-25-11.

The Tenant was independent with transfers and ambulation. According to incident reports, the Tenant fell on 9-25-10, resulting in a bruised area to the forehead and eye area. The Tenant did not require medical attention following the fall. The Tenant also fell on 10-18-10, tearing the skin on his/her arm. All documented bruising could be correlated with recent falls. Staff #9, RNC, documented follow up to all of Tenant #8's noted falls within one day of each fall.

During September and October 2010, Tenant #8 experienced rectal bleeding due to hemorrhoids. The nurse made multiple assessments of the Tenant's bleeding with appropriate follow up with the Tenant's physician during September and October 2010.

The Tenant fell again on 1-1-11, resulting in a hip fracture. The nurse performed appropriate evaluations following the Tenant's return from the hospital on 1-18-11. The nurse initiated staff member assistance with transfers and ambulation. The Tenant's condition worsened and he/she was admitted to hospice on 1-25-11, dying on 2-16-11 with no relation to the fall on 1-1-11.

Tenant #9 (the Tenant) was independent with transfers, ambulation and toileting prior to 3-17-11. Tenant #9 experienced occasional documented bruising secondary to falls. All documented bruising could be correlated with recent falls. Staff #9, Registered Nurse Coordinator (RNC), documented follow up to all of Tenant #9's noted falls within one day of each fall.

Tenant #11 (the Tenant) experienced occasional documented bruising secondary to falls. All documented bruising could be correlated with recent falls. Staff #9, RNC, documented follow up to all of Tenant #11's noted falls within one day of each fall.

- Regulatory Insufficiency: None noted.

D. Criteria for Admission and Retention of tenants

Complaint/Incident Allegation: It was alleged the program retained multiple tenants despite changes in health status which resulted in increased dependence upon staff members for the provision of activities of daily living. It was alleged the program retained one tenant whose behaviors placed other tenants at an increased risk for injury. It was alleged one tenant eloped from the program without successful staff intervention, requiring police involvement.

- Monitoring Observation: Tenant #4 (the Tenant), an 81 year old, was admitted on 1-18-08, died 11-2-11 and had documented diagnoses of Dementia and HTN. The Tenant scored at a 7 on the 10-31-11 GDS, indicating very severe cognitive decline and previously resided in the program's dedicated memory care unit.

The Tenant was admitted to hospice on 7-6-11. The Tenant's condition gradually deteriorated. The Tenant required assistance from staff members for eating, bathing, grooming, dressing, toileting, medication administration, transfers and ambulation. On 10-31-11, the Tenant began refusing to eat all foods, began refusing all medications and became bed bound, requiring frequent positioning by staff members. On 11-1-11 the program applied for a waiver to allow the Tenant to remain at the program. The Tenant died on 11-2-11 prior to the program obtaining the waiver. The Tenants dependence and bed bound status was a result of the dying process and the Tenant died within 3 days.

Tenant #7 (the Tenant) previously resided in the program's dedicated dementia units. He/she was admitted to hospice on 7-7-10 due to a declining condition. The Tenant died while under the care of hospice on 11-15-10. According to the service plan, dated 11-5-10, the Tenant required reminding and cueing during meals, assistance of one staff member with transfers, used a wheelchair for mobility with staff propelling the wheelchair and required assistance with bathing, toileting, dressing, grooming and medication administration.

Tenant #8 (the Tenant) previously resided in the program's dedicated dementia units. He/she was admitted to hospice on 1-25-11 due to a declining condition. The Tenant died while under the care of hospice on 2-16-11. According to the service plan, dated 1-25-11, the Tenant required assist of one staff member to feed him/her at times, assistance of one staff member with transfers and ambulation and required assistance with bathing, toileting, dressing, grooming and medication administration.

Tenant #9 (the Tenant) required assistance with eating, bathing, grooming, dressing, toileting, medication administration, transfers and ambulation. The Tenant was admitted to hospice on 2-21-11. On 3-17-11, the Tenant began requiring routine two person transfer assistance due to a declining condition. On 3-17-11 the program applied for a waiver to allow the Tenant to remain at the program. The Tenant died on 4-9-11 prior to the program obtaining the waiver. The Tenants dependence and bed bound status was a result of the dying process and the Tenant died within 3 weeks.

Tenant #10 (the Tenant), a 74 year old, was admitted on 4-18-11 and had a documented diagnosis of Lewey Body Dementia. The Tenant was scored at a 5 on the 4-10-11 GDS, which indicated moderate severe cognitive decline and resided in the program's dedicated memory care unit from 4-18-11 until 4-23-11.

According to the initial evaluation and corresponding service plan, dated 4-18-11, the Tenant was independent with transfers, ambulation and eating. The Tenant required staff member assistance with bathing, dressing, grooming, toileting and medication assistance. The incident report, dated 4-23-11, documented Tenant #10 became agitated. He/she picked up a chair and threw the chair at Staff #4, CMA. The windows in the memory care unit were raised to allow fresh air. Tenant #10 began punching and ripping out the window screens, climbing through one of the windows and exiting the building. Staff members alerted other staff members in the main assisted living area to the Tenant's exit by radio. Those staff members intercepted the Tenant in the program's parking lot and were able to successfully redirect the Tenant back into the building.

The Tenant remained resistive and combative, requiring transfer to the hospital for a psychiatric evaluation. Tenant #10 was admitted to the hospital's behavioral health unit and did not return to the program. The program discharged the Tenant on 5-2-11 without his/her return to the program.

The Tenant had not exhibited exit seeking or aggressive behavior prior to 4-23-11. The Tenant was not out of the building without staff member knowledge and staff members were able to return the Tenant without losing sight of him/her. The program acted appropriately by transferring the Tenant for a psychiatric evaluation and the Tenant did not return to the program following the incident.

Tenant #11 (the Tenant) previously resided in the program's dedicated dementia units. The Tenant was admitted to hospice on 8-8-11 and died on 8-10-11. According to the service plan, dated 7-15-11, the Tenant required some assistance with eating on occasion, required the assistance of one staff member for transfers, ambulation, dressing, toileting, bathing, grooming and medication administration. On 8-8-10 the Tenant became bed bound, used a mechanical lift if he/she was required to get out of bed. The Tenant's changes in dependence with the above stated personal care tasks were a direct result of the dying process and the Tenant died within 2 days of the changes.

Tenant #12 (the Tenant) previously resided in the program's dedicated dementia units. He/she was admitted to hospice on 8-12-10 due to a declining condition. The Tenant died while under the care of hospice on 12-1-10. According to the service plan, dated 9-30-10 and updated 10-25-10, the Tenant required reminding and cueing during meals, assistance of one staff member with ambulation if he/she was weak or dizzy, standby assistance with bathing, and assistance with toileting, grooming and medication administration. Progress Notes documented on 11-29-10 the Tenant's condition began deteriorating, resulting in dependence with all of the above stated personal care tasks and the Tenant became bed bound. The Tenant died on 12-1-10. The Tenants dependence and bed bound status was a result of the dying process and the Tenant died within 2 days.

The monitors found the reviews related to Tenants #4, #7, #8, #9, #10, #11 and #12 showing no concerns related to level of care issues; however, the monitors did identify the following concerns related to level of care issues for Tenant #13:

Tenant #13 (the Tenant), a 95 year old, had an admission date of 3-15-11, died on 3-29-11 and had documented diagnoses of Dementia with Hallucinations and Delusions, HTN, Glaucoma and Prostate Cancer with subsequent radiation. The Tenant was scored at a 4 on the 3-15-11 GDS, which indicated moderate cognitive decline. The Tenant previously resided in the program's dedicated memory care unit.

According to the evaluation and corresponding service plan, dated 3-15-11, the Tenant was independent with transfers and ambulation. He/she required the assistance of one staff member for grooming, bathing, dressing and toileting.

The Tenant's clinical record contained documentation of the Tenant's repeated history of vivid visual hallucinations, paranoid thoughts, threats of suicide and threats of harming others, including family members prior to admission to the program.

The Tenant had been wandering away from home, asking neighbors and the mailman for guns so he could shoot people, urinating and defecating all over his/her home and refusing to eat or take medications. On 3-3-11, the Iowa District Court issued an order for a psychiatric evaluation following determination that the Tenant was seriously mentally ill and presented a danger to him/her self and others. He/she was subsequently admitted to the hospital for evaluation and treatment. A court date to determine court ordered placement was scheduled for 3-8-11 following the evaluation period.

According to hospital documentation, dated 3-4-11, it was determined the Tenant was considered to be a danger to him/her self and others, as well as suffered from a major mental illness and was in need of placement. The hospital documentation indicated placement had been found at the Bickford Cottage in Burlington with a bed hold placed by the Tenant's family. The plan was to keep the Tenant hospitalized until the court hearing on 3-8-11, and then transfer the Tenant by ambulance to the Burlington program. Low doses of Seroquel and Risperidal would be initiated to assist with behavior control.

The Tenant was discharged from the hospital and taken to Bickford of Burlington on 3-15-11. The Tenant's service plan indicated the Tenant had "some delusions and hallucinations" requiring redirection to watch TV, talk about the Tenant's hobbies or offer food/snacks. If unable to redirect, staff members should call the nurse for permission to administer as needed psychoactive medications.

The narrative notes contained no documentation related to the Tenant's behaviors from admission until his/her time of death. The Tenant began passing large blood clots rectally, requiring admission to the hospital where the Tenant subsequently died on 3-29-11.

The program knowingly accepted admission of the Tenant despite his/her acute mental illness symptoms of suicidal threats, homicidal threats, paranoid behaviors and thoughts and vivid visual hallucinations.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who is dangerous to self or other tenants or staff or a tenant who is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness. (IACr. 481.69.23(1)c.d.)

E. Involuntary Discharge

Complaint/Incident Allegation: It was alleged the program unjustly initiated an involuntary discharge for one tenant.

- Monitoring Observation: The monitors reviewed the occupancy agreement of Tenant #5 who was involuntarily discharged by the program, which was initiated by the program. The occupancy agreement included a statement giving either party the ability to terminate the landlord-tenant agreement at any time as long as a 30 day notice was given. Tenant #5's DPOA signed the agreement on 6-22-10.

There were no other tenants in the previous six months who had received an involuntary discharge initiated by the program.

- Regulatory Insufficiency: None noted.

F. Service Plans

Complaint/Incident Allegation: It was alleged the program did not adequately identify each tenant's individualized needs and assure staff members provided care as directed in each tenant's service plan.

- Monitoring Observation: The monitors reviewed the service plans for Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 and #13, finding all service plans reflecting the individualized needs of each tenant.

- Regulatory Insufficiency: None noted.

G. Nurse Review

Complaint/Incident Allegation: It was alleged the nurse did not adequately assess and document changes in tenant health status or assess concerns in a timely manner.

- Monitoring Observation: The monitors reviewed the clinical records of Tenants #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 and #13, finding nurse reviews completed as required for each tenant.

- Regulatory Insufficiency: None noted.

H. Structural Requirements

- Monitoring Observation: On 11-8-11 the monitors observed Tenants #1 and #2 to be unattended in the common area of the memory care unit from 7:45 PM until 8:03 PM while Staff #1, CMA, assisted Tenant #3 in his/her room. On 11-8-11 the monitors observed Tenants #1 and #3 to be unattended in the common area of the memory care unit from 8:05 PM to 8:17 PM while Staff #1, CMA, assisted Tenant #2 in his/her room. No other staff members were present in the memory care unit during this time.

  On 11-8-11 at 8:20 PM, the monitors noted the swinging doors entering the kitchen area to be unsecured. A toaster oven, toaster, coffee pot and hot plate were all sitting on the counters and plugged in. A cupboard located underneath the sink in the kitchen area was unlocked. The cupboard contained four 75 ounce bottles of Liquid Dishwasher Gel, which contained the statement "Harmful if swallowed"; one bottle of Dawn dish soap, which contained the statement "Keep out of reach of children"; and one gallon bottle of Sani T 10, a liquid disinfectant, which contained the statement "Keep out of reach of children" and "danger- burns to skin".

The monitors also noted the beauty salon door light was shining and the door was unlocked. The beauty salon was located in the same open area of the common area in the memory care unit. The monitors found two bottles of fingernail polish remover sitting out in the open in the salon. Both bottles contained the warning "harmful if ingested- call poison control".

Staff #1, CMA, reported the cupboard under the sink in the kitchen is usually locked; however, he may have inadvertently left it unlocked earlier in the evening after taking something out of the cupboard. Staff #1 did not know if the beauty salon doors were routinely left unlocked and was unable to find a key to lock the door.

The program had items available to unattended cognitively impaired tenants that presented a potential danger for injury.

- Regulatory Insufficiency: The buildings and grounds shall be well-maintained, clean, safe and sanitary. (IAC r. 481-69.35(1)(b))

I. Other

Complaint/Incident Allegation: It was alleged program staff did not notify guardians of tenants with dementia of falls in a timely manner.

- Monitoring Observation: The monitors reviewed incident reports for Tenants #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11. All incident reports following falls documented guardian notification in a timely manner.

- Regulatory Insufficiency: None noted.

Complaint/Incident Allegation: It was alleged a tenant had personal items stolen and the program did not follow up appropriately.

- Monitoring Observation: Tenant #9, a confused tenant living in the program's dedicated memory care unit, was independent with transfers, ambulation and toileting. In December 2010, his/her family noted two rings missing. The program's investigation documentation indicated staff members located one ring by the toilet in the bathroom and never found the other ring. The Director reported a belief that Tenant #9 may have flushed the ring down the toilet when toileting independently. The program did not determine the second ring had been stolen since the first ring was found therefore did not follow up any further with the investigation.

- Regulatory Insufficiency: None noted.