IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 36726-C

January 24, 2012

Ms. Annette Grochala, Director
Bickford Cottage of Urbandale
5915 Sutton Place
Urbandale, IA 50322

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

Dear Ms. Grochala:

I. Final Complaint/Incident Investigation Report – Bickford Cottage of Urbandale, Urbandale, 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: Program reporting to Department, Medications and Structural Requirements. **Bickford Cottage of Urbandale** ("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 **Rose Boccella** 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 January 17, 2012, has been reviewed and will constitute the final POC related to the on-site visit of December 21 & 22, 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:

Annette Grochala, Director
Bickford of Urbandale
5915 Sutton Place
Urbandale, IA 50322

Complaint/Incident Intake #: 36726-C

Date of Complaint/Incident Investigation:

December 21 and 22, 2011

Monitor(s):

Lori Miner, RN BSN

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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	18
Number of tenants with cognitive disorder:	7
Total Population of Program at time of on-site	25

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	9
TOTAL census of Assisted Living Program	34

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.

During the August 24 and 25, 2011 Incident Investigation (33682-I) the program received regulatory insufficiencies in the areas of Food Service, Dementia Education and Plan of Correction.

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

A. Tenant Rights

Complaint/Incident Allegation: It was alleged Tenant #1 had only a mattress on the floor with no clothing or other furniture in the room.

- Monitoring Observation: Tenant #1, an 89 year-old, was admitted on 12-18-08 and had diagnoses of Depressive Disorder, Dementia, Alzheimer's, Hypertension, and Osteoarthritis. Tenant #1 was staged at five on the Global Deterioration Scale (GDS which indicated moderately severe cognitive decline. Tenant #1 resided in the locked dementia unit. Tenant #1's apartment was observed. A box spring and mattress were stacked on the floor. The room was furnished and clothes were in the closet. The

Director stated the Tenant was short and had difficulty getting in and out of bed when it was on a bed frame. She also stated the family did not have a concern about the bed arrangement. Staff #1 stated the family requested the Tenant's bed be off the frame as Tenant #1 had a history of falls. Tenant #1 had a diagnosis of Osteoarthritis and received as needed pain medication three times during the month of November.

Tenant #1's apartment was furnished with a bed in the room. The bed had been adjusted to meet the needs of the Tenant. The Tenant's file did not contain documentation of pain related to the bed being on the floor.

- Regulatory Insufficiency: None noted.

B. Program Reporting to the Department

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #2, an 88 year-old, was admitted on 6-27-08 and had diagnoses of Gastroesophageal Reflux Disease, Alzheimer's Dementia, Benign Prostatic Hypertrophy with indwelling catheter in place. At the time of the fall, Tenant #2 was staged at five on the Global Deterioration Scale which indicated moderately severe cognitive decline. An incident report dated 10-1-11 documented Tenant #2 was in the dementia unit. The report stated Tenant #2 was walking in the living room on the way to the dining room and tripped on the strip between the living room and dining room and fell, landing on the left side. Tenant #2 was transported to the hospital and admitted for a left hip fracture. The service plan dated 7-11-11, current at the time of the fall, indicated Tenant #2 was independent with ambulation. It was noted Tenant #2 did not use assistive devices and had a steady gait. The Director stated Tenant #2 shuffled feet and did not pick them up. She also indicated the fall had not been reported to the department as Tenant #2 was independent. The Fall Investigation report signed by the nurse and the Director identified the Tenant tripped on the strip between the carpet and vinyl flooring.

  The flooring in the dementia unit was observed during the onsite visit. A hard strip was noted to be between the vinyl flooring of the dining room and the carpet. The strip was raised and created an uneven surface.

  The incident report and the Fall Investigation report indicated the Program had culpability related to the fall. The incident should have been reported to the department.

- Regulatory Insufficiency: Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury. "Major injury" shall be defined as any injury which requires admission to a higher level of care for treatment, other than for observation. (IAC r. 481-67.4(1)(a)(2))

C. Medications

Complaint/Incident Allegation: It was alleged the 4 p.m. and 7 p.m. medications were given at the same time.

- Monitoring Observation: This monitor made an unscheduled visit to the Program from approximately 5 p.m. to 6 p.m. on 12-21-11. Staff #3 was asked to provide the Medication Administration Records (MARs) for all tenants. The Program had the MARs in three notebooks. Staff #3 indicated he was passing medications to tenants in the main portion of the building as well as the bistro. Another staff person, Staff #1, was passing medications in the dementia unit. All three notebooks were checked for documentation of the administration of 4 p.m. and 8 p.m. medications at the same time. There was no documentation of medications being administered at the same time in the dementia unit. Three tenants who received both 4 p.m. and 8 p.m. medications were randomly selected from both the main and bistro section. Bubble packs were empty for 4 p.m. and contained 8 p.m. medications. The MAR for Tenant #3 contained documentation of the administration of two 8 p.m. medications. The bubble pack contained the medications, so they indeed had not been given. Staff #3 had no explanation.

  There was no documentation to suggest that 4 p.m. and 8 p.m. medications had been given at the same time.

- Regulatory Insufficiency: None noted.

During the course of the investigation, the following was noted:

- Monitoring Observation: MAR's were reviewed for all tenants on 12-21-11 shortly after 5 p.m. Documentation for Tenant #3 indicated the Tenant had received 8 p.m. medications, which would be three hours before the scheduled time. The pills were noted to be in the bubble packs. The documentation was not accurate. Tenant #4 had documentation of 8 p.m. eye drops, three hours early. Staff #3 stated the time was different on a previous MAR and that the eye drops had been administered. Tenant #5 had no documentation of eight morning medications on 12-21-11. Two tenants, #6 and #7, did not have documentation of the administration of 4 p.m. topical medications. The Medication Administration policy provided by the Program indicated documentation would be done immediately after administration of the medication, and that an accurate up-to-date medication administration record shall be maintained.

  The Program failed to follow procedures set forth by the Program as well as accepted professional standards for medication administration.

- Regulatory Insufficiency: When medications are administered traditionally by the program: The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655—Chapter 6 governing nurse delegation (IAC r. 481-67.5(6)(a))

D. Staffing

Complaint/Incident Allegation: It was alleged Tenant #2 fell and broke a leg because there was not enough staff in the dementia unit.

- Monitoring Observation: Tenant #2 resided in the dementia unit. An incident report dated 10-1-11 stated Tenant #2 was walking in the living room on the way to the dining room and tripped on the strip between the living room and dining room and fell, landing on the left side. Tenant #2 was transported to the hospital and treated for a left hip fracture. The service plan dated 7-11-11, current at the time of the fall, indicated Tenant #2 was independent with ambulation. It was noted Tenant #2 did not use assistive devices and had a steady gait. The Director stated Tenant #2 shuffled his/her feet and did not pick them up.

  Two staff members, #1 and #2, who were working in the dementia unit, were interviewed. Both staff members stated there was enough staff in the dementia unit to meet the needs of the tenants. Staff #2 stated there was time to spend with the tenants.

  The dementia unit was observed during the onsite visit. Two staff members were seen in the unit assisting with activities, food, and personal needs. Staff members were observed attending to the tenants needs.

  The incident report documented the Tenant tripped over a strip between the vinyl flooring and the carpet. The Tenant was independent with ambulation at the time of the fall.

  Staff was not involved in the Tenant's fall.

- Regulatory Insufficiency: None noted.

E. Food Service

Complaint/Incident Allegation: It was alleged the food was not good.

- Monitoring Observation: Menus were reviewed for November and December 2011. The menus were signed by a dietitian. The Kitchen Manager had a current serve-safe certificate. The kitchen had a current food license. The noon meal was observed in both units on 12-21-11. The tenants in both areas were observed readily eating the food. A tenant in the dementia unit asked for seconds. The Kitchen Manager reported the food temperatures were checked before taking the food back to the dementia unit. The food served was what was indicated on the menu. Spaghetti was sampled and found to be appropriately hot. The noodles were cooked but not mushy. Fruits and vegetables were also served. Staff #2 stated the food in the dementia unit was "wonderful" and she did not know of any complaints about the food.

  There was nothing noted to suggest a problem with the food.

- Regulatory Insufficiency: None noted.

F. Activities

Complaint/Incident Allegation: It was alleged there were no activities in the dementia unit, and nothing for the tenants to do.

- Monitoring Observation: The Activity Director provided activity calendars for both the general area as well as the dementia unit. The Activity Director stated staff members were scheduled to provide activities in the dementia unit. The staff schedule was reviewed and indicated the same. The Activity Director stated there were many activities to do in the dementia unit, and if the tenants did not want to do a scheduled activity, options were available. Tenants in the dementia unit also attended activities in the general area. Staff #1 stated activities were done on the weekends.

  Three staff members were interviewed. Staff #1, working in the dementia unit at the time of the interview, stated there are "lots of activities" including movies, arts and crafts, and one-to-one activities. Staff #1 stated there are two persons assigned to work in the dementia unit and the second person does activities. Staff members try to follow the schedule provided by the Activity Director, but if tenants aren't interested, staff switches the activity to something else.

  Staff #2, working in the dementia unit at the time of the interview, stated an activities person is assigned, but the staff members work as a team and both persons assigned to the dementia unit provide activities. One-to-one activities are provided. Staff members work from the activity schedule provided by the Activity Director. Staff #2 stated there are "lots of supplies" for activities.

  Staff #4, who works in the dementia unit, including weekends, indicated crafts, movies, board games, sing-a-longs, as well as other activities are provided in the dementia unit. Staff #4 stated there was a person assigned to do activities in the unit, and an activity schedule was provided to staff. Staff #4 stated there never was a time there haven't been activities. She also stated if the tenants were not interested, another activity is found.

  During the course of the monitoring visit, tenants were observed in the dementia unit doing a balloon toss; some tenants were taken to the general area for bible study. Of the nine tenants residing in the dementia unit, seven were engaged in an activity during one observation. While interviewing Staff #2, Staff #1 were observed doing a one-to-one activity with a tenant.

  In the afternoon, eight tenants were in the living room for a read-aloud group. One tenant was taking a nap.

  The activities done were as indicated by the Activity Director on the activity calendar.

  The Program was providing activities to the tenants.

- Regulatory Insufficiency: None noted.

G. Structural Requirements

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #2 resided in the dementia unit. An incident report dated 10-1-11 stated Tenant #2 was walking in the living room on the way to the dining room and tripped on the strip between the living room and dining room and fell, landing on the left side. Tenant #2 was transported to the hospital and admitted for a left hip fracture. The Fall Investigation report accompanying the incident report indicated Tenant #2 tripped on the strip between the carpet and vinyl flooring. Actions taken were listed as advising staff to send Tenant #2 to the emergency room for evaluation. There were no interventions listed for the strip on the floor.

  The flooring in the dementia unit was observed during the onsite visit. A hard strip was noted to be between the vinyl flooring of the dining room and the carpet. The strip was raised and created an uneven surface. Tenant #1 was observed trying to roll a walker over the strip. The walker wheel momentarily got stuck on the strip until Tenant #1 pushed harder and rolled the walker over the strip.

  Program staff documented in an incident report that a tenant tripped over a strip on the floor in the dementia unit. The Fall Investigation report indicated the Program did not take action to correct the identified problem. The floor surface was noted to be uneven because of the strip.

  The Program identified the strip on the floor of the dementia unit, between the vinyl flooring and the carpet, as the reason for a tenant falling.

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