IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

**DEMAND LETTER**
**CERTIFIED**
**Complaint Intake #: 39840-C**

August 20, 2012

Mr. Michael Early, Director
Bickford Cottage Ames
2418 Kent Avenue
Ames, IA 50010

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

Dear Mr. Early:

**I. Final Complaint/Incident Investigation Report – Bickford Cottages Ames, Ames, 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: Criteria for Exclusion of Tenants and Policies and Procedures.

**Bickford Cottage Ames** is being assessed a $1,000 civil penalty. The Program failed to comply with regulatory requirements. The non-compliance resulted in imminent danger or a substantial probability of resultant death or physical harm to a tenant. The Program retained a tenant for four months despite tenant's pattern of acts exhibiting exit-seeking attempts, disruption to other tenants' personal items, agitation with physical aggressiveness with staff members, touching of staff members and other tenants in a sexual manner on multiple occasions and exposing his/her genitals in common areas of the program.

## 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 to the State of Iowa 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.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on August 7, 2012, has been reviewed and will constitute the final POC related to the on-site visit of July 10, 11 and 12, 2012.

~~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:**

Michael Early, Director
Bickford Cottage Ames
2418 Kent Ave.
Ames, Iowa 50010

**Complaint/Incident Intake #:**

39840-C

**Date of Complaint/Incident Investigation:**

July 10, 11, and12, 2012

**Monitor(s):**

Maribeth Freland 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.

| Dementia-Specific Program by Definition | |
|---|---|
| Number of tenants without cognitive disorder: | 27 |
| Number of tenants with cognitive disorder: | 6 |
| Total Population of Program at time of on-site | 33 |
| **TOTAL census of Assisted Living Program** | 33 |

**Program History** – The program did not receive any regulatory insufficiencies during this certification period.

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

**A. Criteria for Admission and Retention**

Complaint/Incident Allegation: It was alleged the program retained a tenant who exceeded the assisted living level of care.

- Monitoring Observation:

Tenant #1, an 80 year old, was admitted to the program on 8-13-10 with diagnoses of: Alzheimer's type Dementia, Coronary Artery Disease, Atrial Fibrillation and Prostate Cancer. Tenant #1 had the diagnoses of Psychosis and Agitation added by his/her physician in February 2012. Tenant #1 resided in the general population area of the program. Tenant #1 scored a 5 on the Global Deterioration Scale (GDS) completed on 1-3-12, indicating moderately severe cognitive decline.

As the assisted living program was dementia specific by definition, the program had all exit doors located within the building secured. All exit doors were locked, requiring a code to be input to release the door locks. Each door had a 15 second emergency egress bar that would emit an audible alarm when being pushed but would release the locks after 15 seconds. Each door had a Wander Guard system which sounded audibly on staff member pagers whenever a tenant wearing a Wander Guard device was in close proximity to the door when opened. Tenant #1 wore a Wander Guard device due previous exit-seeking behavior.

Progress note, incident reports, physician notes, medication administration records (MARs) and staff member interviews documented the following:

On 10-10-11, Tenant #1 exited the building when visitors were entering the program. The Wander Guard device triggered the alarm system. Staff members responded,

seeing Tenant #1 exit the building. Tenant #1 was easily redirected back into the building.

On 10-16-11, Tenant #1 exited the building when visitors were entering the program. The Wander Guard device triggered the alarm system. A staff member located outside of the building located Tenant #1. Tenant #1 was easily redirected back into the building.

On 10-17-11, Tenant #1 exited the building without staff member knowledge. The Wander Guard device triggered the alarm system. Staff members responded, found Tenant #1 outside of the building. Tenant #1 was able to be redirected back into the building.

On 11-3-11, Staff #1, the previous registered nurse (RN), documented Tenant #1 continued to exhibit anxiety and exit-seeking behaviors. The physician ordered Lorazapam, an anti-anxiety medication, as needed for agitation.

November 2011 MARs documented staff members administered Lorazepam to Tenant #1 for agitation and anxiety on November 10, 16, 17, 19, 22, 24, 28, 29, and 30, 2011. The medication was not effective on November 10, 16, 19, 30, and 2011.

December 2011 MARs documented staff members administered Lorazepam to Tenant #1 for agitation and anxiety on December 16, 17, and 24, 2011. The medication was not effective on 12-24-11.

On 12-14-11, Staff #2, an on-call RN, documented Tenant #1 was experiencing insomnia. On 12-15-11, the physician ordered Tylenol PM to help decrease the insomnia.

On 12-24-11, Tenant #1 was wandering into other tenants' apartments disturbing personal belongings. Tenant #1 became combative with staff members when attempting to redirect. Tenant #1 continued to enter other tenant apartments despite staff member intervention. Tenant #1 was making inappropriate sexual comments to staff members and other tenants with ineffective redirection by staff members. Tenant #1's behaviors escalated requiring his/her family members to visit. Tenant #1 calmed during the family visit and slept for approximately one hour. Tenant #1's family left the program. Upon awakening, Tenant #1 again wandered into other tenants' apartments disturbing personal belongings requiring one-to-one supervision by a staff member. Tenant #1's behaviors continued to escalate, requiring staff members to contact Staff #2, the on-call RN. Staff #2 arrived at approximately 6:00 p.m. Staff #2 documented observing Tenant #1 touching the medication aide in a sexual manner while giving medications. The RN attempted to redirect Tenant #1 by walking around the inside of the program multiple times. Tenant #1 was making inappropriate sexual comments to staff members and other tenants while ambulating. Tenant #1 was attempting to touch Staff #2 in a sexual manner. After unsuccessful redirection attempts, law enforcement was summoned and Tenant #1 was transported to the emergency room for medical evaluation of the inappropriate behaviors. Tenant #1 was admitted for a psychiatric evaluation. During interview, Staff #3, CMA, and Staff #5, CMA, both who worked on the evening of 12-24-11, verified the above documented information as accurate.

On 12-26-11, Tenant #1 arrived back at the program accompanied by Tenant #1's legal representative. Documentation indicated no prior notification was received from the hospital of Tenant #1's planned discharge. The emergency room physician had discontinued the use of Tylenol PM, Lorazepam, Namenda and the Exelon patch. The physician did not replace any of these medications with any medications for behavior control.

Later in the day on 12-26-11, Tenant #1 began entering other tenants' apartments one after another. Staff members diverted Tenant #1's attention while going around the program locking all other tenants' apartment doors. When Tenant #1 discovered the locked doors, Tenant #1 became belligerent, demanding the doors be unlocked. Tenant #1 paced the hallways and rearranged furniture in the program's common areas for two hours.

On 12-27-11, Staff #1, the previous RN, spoke with Tenant #1's legal representative about Tenant #1's behaviors and the possible need for placement in another setting. Tenant #1's legal representative expressed a wish for Tenant #1 to remain at the program.

On 12-29-11, Staff #1, the previous RN, sent Tenant #1's physician a note documenting Tenant #1 had been experiencing increased anxiety, agitation and exit-seeking behaviors for approximately one month prior. Staff #1 documented Tenant #1 had a "psychotic episode" on 12-24-11, noting Tenant #1 exhibited extreme agitation, disturbed other tenants' belongings, hit at staff members, threw objects and made "inappropriate sexual advances/comments toward staff members and female tenants- tried to fondle". Tenant #1 went to physician's appointment and returned with Namenda and the Exelon Patch reinitiated.

On 1-3-12, Staff #2, on-call RN, documented Tenant #1 was "touching staff members and other tenants inappropriately" and had been exposing his/her genitals in common areas. Staff #2 documented "family is aware of need for higher level of care."

On 1-6-12, Staff #2, on-call RN, documented Tenant #1 had been exhibiting "psychotic" behaviors on a daily basis. Staff #1, previous RN, sent Tenant #1's physician a note reiterating Tenant #1 had experienced a "psychotic episode on 12-24-11, noting Tenant #1 had "made sexual advances, verbal and physical- touching other tenants and staff". Staff #1 documented Tenant #1 continued to make sexual advances and seek exit from the building. Tenant #1 went to a physician's appointment and returned with Seroquel, an anti-anxiety medication, initiated at bedtime.

During interview, Staff #3, CMA, and Staff #4, CMA, reported working the evening shift on 1-10-12. Both reported Tenant #4, a tenant who previously resided at the program and exhibited moderate cognitive decline (GDS of 4), wandered out into the common areas of the program in his/her wheelchair. Tenant #4 appeared frightened and was shaking. Tenant #4 told Staff #3 and #4 that another tenant had entered his/her apartment, unstrapped the abductor splint that was placed between Tenant #4's thighs, touched Tenant #4 "inappropriately" and then made Tenant #4 get out of bed. Both staff members reported immediately searching for all apartments, finding

Tenant #1 in Tenant #3's apartment. Tenant #3, a tenant currently residing at the program, exhibited moderate cognitive decline (GDS of 4), was found in his/her bed accompanied by Tenant #1. Tenant #3 was staring straight ahead and appeared to be frightened. Staff #3 reported Tenant #1 and Tenant #3 were both dressed in nightclothes. Tenant #1 had one hand wrapped in Tenant #3's hair and the other hand under the covers. Tenant #1 appeared to be masturbating over his/her clothes. Tenant #3 and Tenant #4's clinical records contained documentation, dated 1-10-12 and written by Staff #3 and Staff #4, that matched the verbal report in detail.

On 1-11-12, Tenant #1 again wandering into other tenant rooms and experiencing "psychotic episodes" and behaviors during the night. Family members were summoned to visit and provide one to one supervision for remainder of the night.

On 1-12-12, Staff #2, the on-call RN, sent a note to the physician documenting Tenant #1's continued inappropriate behaviors. Staff #2 documented Tenant #1 touched two different tenants inappropriately and performed sexual acts on him/herself during the overnight shift. The physician increased Tenant #1's Seroquel dose at bed time. Administration discussed potential need for Tenant #1 to seek a higher level of care if behaviors continue.

On 1-21-12, Tenant #1 was awake all night, pacing hallways and knocking on other tenants' apartment doors. Tenant #1 was agitated with staff members.

During interview, Staff #3, CMA, reported Tenant #1 masturbated frequently during bathing assistance by staff members. Tenant #1 would make suggestive remarks to staff members during bathing assistance. Staff #3 reported she observed Tenant #1 reach under the dining room table and rub the legs of two tablemates, Tenant #2, a moderately cognitively impaired tenant (GDS of 4) currently residing at the program, and Tenant #3 on multiple occasions. Tenant #1 would then move his/her hands to Tenant #2 and #3's genital area, masturbating each over their clothing. Tenant #1 could be redirected but again do the same on other occasions. Staff #3 reported this to Staff #2, the on-call RN. Tenant #1 was eventually moved to another table consisting of only tenants of the same sex as Tenant #1.

During interview, Staff #2, the on-call RN, reported Staff #3, CMA, did report observing Tenant #1 rubbing the genitals of Tenant #2 and Tenant #3 on multiple occasions. Staff #2 indicated Tenant #1 was moved to another table consisting of only tenants of the same sex as Tenant #1.

During interview, Staff #4, CMA, reported Tenant #1 frequently made sexually suggestive remarks to his/her tablemates, eventually requiring Tenant #1 to be moved to a table consisting of only tenants of the same sex as Tenant #1.

During interview, Staff #5, CMA, reported Tenant #1 frequently exposed his/her genitals in common areas of the program. She reported Tenant #1 frequently made sexually suggestive comments to staff members and other tenants. Tenant #1 sat at a table with Tenants #2 and #3; however, Tenant #1 made sexual comments and rubbed the knees of Tenant #3 causing administration to move Tenant #1 to a table consisting of only tenants of the same sex as Tenant #1. Staff #5 reported Tenant #1 would make sexually suggestive comments to staff members when assisting with bathing.

During interview, Staff #6, CMA, reported Tenant #1's behaviors became inappropriate in the evenings. Tenant #1 wrote on walls, wandered into other tenants' apartments disturbing personal belongings, made multiple elopement attempts and made sexual comments to staff members and other tenants. Staff #6 reported Tenant #1 had tried to kiss her, grabbed her buttocks and once grabbed her genital area. Staff #6 reported she told the Director each time this behavior occurred.

During interview, the previous Divisional RN reported she had returned from leave on 2-29-12. After completing a chart audit, the RN had concerns with documentation found in Tenant #1's clinical record documenting sexual inappropriateness. The Divisional RN immediately initiated an investigation on 3-1-12; however, she did not find staff members could give actual dates of occurrence and had conflicting information given to her so she did not precede with any follow-up due to the time lapse. The Divisional RN believed Tenant #1's behaviors had improved by this time therefore Tenant #1 was allowed to remain living at the program.

During interview, the Director reported he did interview staff members about Tenant #1's sexually inappropriate behaviors; however, he did not do so until after the previous Divisional RN initiated her investigation. The Director also felt like staff members could not give actual dates of occurrence therefore Tenant #1 was allowed to remain living at the program.

Tenant #1 eloped from the program on 4-1-12. While trying to redirect Tenant #1 back into the program, Tenant #1 fought with Staff #5, CMA, causing both the tenant and the staff member to fall onto the ground. Neither received any injuries. Tenant #1 stood immediately and, as Staff #5 was trying to stand, Tenant #1 pulled on her legs in an attempt to send her back to the ground. Other staff members intervened and Tenant #1 was returned to the program.

On 4-12-12, the Director gave Tenant #1's legal representative an involuntary 30 day discharge notice. Tenant #1 moved to another local assisted living program on 5-12-12.

The program retained Tenant #1 living at the program for four months despite Tenant #1's pattern of acts exhibiting exit-seeking attempts, disruption to other tenants' personal items, agitation with physical aggressiveness with staff members, touching of staff members and other tenants in a sexual manner on multiple occasions and exposing his/her genitals in common areas of the program.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: a. Is bed-bound; or b. Requires routine, two-person assistance with standing, transfer or evacuation; or c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually aggressive or abusive, or displays unmanageable verbal abuse or aggression; or (2) Displays behavior that places another tenant at risk; or d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; or e. Is under the age of 18; or f. Requires more than part-time intermittent health related care; or g. Has unmanageable incontinence on a routine basis despite an individualized toileting

program: or h. Is medically unstable; or i. Requires maximal assistance with activities of daily living. (IAC r. 481-69.23(1))

During the investigation, the monitor identified the following:

**B. Policies and Procedures**

- Monitoring Observation: During interview, the Director reported having an inability to locate multiple incident reports for monitor review. Tenant #1 eloped from the program on 2-8-11, 6-26-11, 10-17-11 and 5-5-12. Staff members reported completing an incident report for each elopement. The program could not produce incident reports for the above stated elopements.

  On 12-24-11, Tenant #1 hit staff members and was sexually inappropriate with staff members. Staff members reported completing an incident report. The program could not produce an incident report for this unusual occurrence.

  On 1-10-12, Tenant #1 was found to have been in bed with Tenant #3 and touched Tenant #4 inappropriately. Staff members reported completing an incident report. The program could not produce an incident report for this unusual occurrence.

  Tenant #1 was reportedly observed touching Tenant #2 and #3 in a sexual manner at the dining room table on multiple occasions. The program could not produce an incident report for this unusual occurrence.

- Regulatory Insufficiency: All accidents and unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. A copy of the incident report shall be kept on file on the program's premises for a minimum of three years. (IAC r. 481-67.2(1)(e)(f))