IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint/Incident Intake #: 39691-C
39501-I

August 15, 2012

Ms. Mary Keen, Director
Bickford Cottage of Urbandale
5915 Sutton Place
Urbandale, IA 50322

RE: I. Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Standard Certification
V. Conclusion

Dear Ms. Keen:

I. Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report – Bickford Cottage of Urbandale (Program), Urbandale, IA

Enclosed is the **Final Complaint/Incident Investigation & Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapter 481—67 and 481—69. The Report notes the Regulatory Insufficiencies in the area(s) of: Medications, Service Plans, and Dementia Specific Education. Bickford Cottage of Urbandale is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

Bickford Cottage of Urbandale is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2). The Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program's continued failure (or refusal) to comply with regulatory requirements within the prescribed time frame established has a direct relationship in the health, safety, or security of tenants. The onsite investigation revealed multiple medication errors.

DIA is accepting the Plan of Correction (POC) following the Program's submission of information.

II. Civil Penalty

If, within thirty (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 penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant in accordance with IAC 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 cover letter to the attention of **Rose Boccella** and remit the penalty assessed by check or money order to the State of Iowa 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 30 days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to IAC chapter 481—10. If the Program appeals, the civil penalty will be suspended, pending the appeal process. If the Program does not appeal, the fine is due within 30 days of notice.

IV. Standard Certification

Enclosed you will find the Assisted Living Program Certificate **S0042** with effective dates of **September 30, 2012** through **September 29, 2014**.

V. Conclusion

The Program is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The POC submitted on August 9, 2012, has been reviewed and will constitute the final POC related to the on-site visit of July 10 & 11, 2012.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal or request a hearing on 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 report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Recertification and Complaint/Incident Investigation Report

Assisted Living Program:

Bickford Cottage of Urbandale
Mary Keen, Director
5915 Sutton Place
Urbandale, IA 50322

Complaint/Incident Intake #: **39691-C**
39501-I

Date of Complaint/Incident Investigation:

July 10th and 11th, 2012

Monitor(s):

Joyce Kix, RN
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:	13
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	22

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	11
Total Population of Program at time of on-site	11

TOTAL census of Assisted Living Program	33

Tenant/Family Satisfaction Results – A meeting was held with ten tenants. The best thing about the Program was the privacy, the food, and the staff. Housekeeping was completed in apartments and common areas to the tenants' satisfaction. Tenants used a call light to request assistance. Staff were reported to respond in 15 minutes. Tenants indicated staff members were trained to assist them. Care given was described as good and staff members were kind. Tenants reported they liked the food and they got enough to eat. Tenants also reported if they asked, they could receive more food. Hot foods were served hot. There were enough activities offered with no suggestions for improvement. The tenants were generally satisfied with the Program and would recommend it to others.

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

Complaint/Incident Investigation – The Complaint/Incident investigators made the observations detailed in the following areas:

A. Tenant Rights

Complaint/Incident Allegation: 39501-I- The Program reported that Staff #1 alleged that on 6-10-12, she overheard what sounded like Staff #2 and #3 providing unkind potentially abusive care to tenants of the memory care unit.

- Monitoring Observation: Staff #5, #6, and #7 stated they were not aware of any staff verbal or physical abusive treatment of tenants.

  Interviews were attempted with Tenant #1, #11 and #12. All resided in the secured memory care unit and were unable to respond appropriately to questions.

The program completed interviews with all staff involved and were unable to determine any injuries occurred.

Staff #1, Certified Nurse Aide (CNA) stated that she reported hearing noises from the room of Tenant #1 to Staff #4 Certified Medication Aide (CMA). Staff #4 acknowledged that Staff #1 told her about noises from Tenant #1's room but never saw any injury or other evidence of abuse. Staff #4 stated that she would write concerns in the staff communication book. The pages from the staff communication book are routinely destroyed as they are not a part of the medical records.

The program reported the allegations to the Urbandale Police department who came to the program to investigate. The police filed a report but did not determine any injury occurred.

The monitor observed staff provide cares for Tenant #1. The tenant refused cares and made moaning noises of protest while staff attempted to provide necessary cares.

- Regulatory Insufficiency: None Noted.

B. Medications

Complaint/Incident Allegation: 39691-C- It was alleged medication errors were made by staff members and tenants were overdosed. It was alleged tenants received medication in pill form instead of liquid.

- Monitoring Observation: Medication error reports were reviewed. Medication errors for Tenant #5 were as follows:
  a. 4-10-12- ten milligrams (mg) of Oxycontin administered instead of five mg of Hydrocodone as ordered
  b. 5-4-12- two tablets of Hydrocodone 5/500 mg administered instead of one as ordered

  Tenant #5, a 93 year-old, was admitted on 4-2-08 and had diagnoses of: General Debility, Diverticulitis, Macular Degeneration, Gastroesophageal Reflux Disease (GERD), Hypertension (HTN), and Osteoarthritis (OA). Tenant #5 was staged at three on the Global Deterioration Scale (GDS) which indicated mild cognitive decline. Tenant #5 resided in assisted living that was dementia-specific by definition. Tenant #5 was admitted to hospice on 7-30-10 with general debility. The clinical record did not identify any adverse effects to the medication errors noted in the medication error reports.

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

A medication pass was observed with Staff #5. Staff #5was observed administering eye drops to Tenant #13. Staff # 5 was observed administering three drops of Refresh eye drops to each eye, one drop right after the other. The electronic medication administration record (MAR) and a review of the physician's order indicated three drops were to be instilled into each eye, but staff was to wait three to five minutes between drops. When the instructions to wait between drops was brought to the

attention of Staff #5 stated "I didn't know that." The eye drops were not administered according to the physician's order.

The clinical record for Tenant #6 was reviewed. Tenant #6, an 87 year-old, was admitted on 5-24-07 and had diagnoses of: Dementia, GERD, IITN, and Chronic Respiratory Wheezing. Tenant #6 was staged at six on the GDS which indicated severe cognitive decline. Tenant #6 resided in the secured dementia unit. The MAR for May 2012 documented beginning May 5, 2012 and ending May 24, 2012, the Proventil, one vial per nebulizer daily, was not given because it was not available; the Program was waiting for pharmacy. The progress notes dated 5-23-12 indicated a fax had been sent to the physician requesting to discontinue the Proventil as Tenant #6 had no symptoms of respiratory distress. The Program was unable to provide a copy of the fax. According to the MAR, the Proventil administration resumed May 24, 2012. A physician's order form, dated 6-13-12 indicated Proventil per nebulizer was to be continued. There was no documentation in the clinical record prior to the progress note of 5-23-12 to indicate the physician had been notified of the inability to give the medication as ordered. The medication was not administered according to the physician's order.

A review of the physician's orders for Tenant #6 revealed a variety of medication forms. Tenant #6 received medications by nebulizer, by tablet/capsule, by liquid, and topically. The order sheet also revealed medication could be crushed as appropriate.

A 90-day nurse review was completed on 5-21-12 which indicated Tenant #6 experienced no adverse reactions to medications. The nurse review did reveal Tenant #6 had an episode of unresponsiveness to verbal or tactile stimuli for a "couple minutes." Family was notified and requested no action be taken. Similar episodes had occurred in the past.

The monitors found multiple medication administration errors but could not verify that solid medication was administered instead of liquid.

Regulatory Insufficiency: When medications are administered traditionally by the program: (a) 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))

C. Staffing

Complaint/Incident Allegation: 39691-C- It was alleged a staff member was drunk and fell asleep while at work. It was alleged there were not enough staff members to evacuate tenants if there was an emergency on the night shift.

- Monitoring Observation: Three staff members were interviewed: Staff # 5, a Certified Medication Aide (CMA), Staff # 6, a Certified Nursing Assistant (CNA), and Staff # 7, a CNA. All three denied having any knowledge of any persons drinking while at work or sleeping while at work. The program provided a schedule from the staffing agency which documented that the agency provided at least one person on a daily basis.

The monitors were unable to review staff schedule prior to 6-24-12 because the director who was terminated kept those on her personal computer. Review of the current schedule documented at least four to five staff scheduled for each shift.

There are no regulatory requirements for the number of staff required beyond a sufficient number of staff trained to implement the accident, fire safety and emergency procedures available at all times, with at least one staff person awake and on duty in the proximate area 24 hours a day.

- Regulatory Insufficiency: None noted.

D. Tenant Documents

Complaint/Incident Allegation: 39691-C - It was alleged that documentation of incident reports had disappeared.

- Monitoring Observation: The program provided documentation of all incidents reports of the incidents involving the tenants reviewed.

  Staff communication notes are completed by all staff to report to the next shift. These notes are destroyed after a short time and do not become a part of any medical record.

- Regulatory Insufficiency: None noted.

During the course of the re-certification survey the following information was identified.

E. Service Plans

- Monitoring Observation: The staff communication log dated 7-4, 6 and 7-9-12 documented the bed and pad alarms for Tenants #4 and #9 were broken.

  Tenant #1, an 83 year old, was admitted 4-14-11 and resided in the secured memory care unit. Tenant #1 had diagnoses of Vascular Dementia, Cardiac Malformation (AVSD), and HTN. Tenant #9 was staged at six on the GDS which indicated severe cognitive decline. The service plan dated 3-21-12 documented under safety that Tenant #1 had a bed and chair alarm to summon staff and a high low bed. The monitor observed Tenant #1 on 7-11-12 lying on a low bed without alarms in place and padded mats on the floor beside the bed.

  Tenant #4, an 81 year old, was admitted on 9-23-2011 and moved to the secured memory care unit on 4-18-12. Tenant #4 had diagnoses of: Parkinsons, Anxiety, Depression, Glaucoma and Vascular Dementia. Tenant #4 was staged at four on the GDS which indicated moderate cognitive decline. The service plan dated 7-3-12 but not yet signed directed under safety for Tenant #4 to utilize bed and chair alarms to summon staff and prevent falls. During tour of the memory care unit on 7-10-12 the monitor observed Tenant #4 seated in a wheelchair without a chair alarm in place. Staff #10 stated the alarms had been broken since the weekend before.

Tenant #9, an 88 year old, was admitted on 11-3-2008 and resided in the secured memory care unit. Tenant #9 had diagnoses of: Alzheimers, HTN and Depression. Tenant #9 was staged at six on the GDS which indicated severe cognitive decline. The service plan dated 5-22-12 directed under safety that bed and chair alarms had been discontinued since the tenant moved to the secure unit. During tour of the memory care unit on 7-10-12 the monitor observed Tenant #9 seated in a wheelchair without a chair alarm in place. Staff #10 stated the alarms had been broken since the weekend before but Tenant #9 was supposed to have one. The monitor observed a chair alarm in place while Tenant #9 was seated in a wheelchair at the dining room table on 7-11-12 at 12:15 p.m.

The service plan for Tenant #1 did not include the use of floor pads and staff failed to place a bed alarm as planned. The service plan for Tenant #4 included bed and chair alarms which were not utilized. The service plan for Tenant #9 indicated bed and chair alarm usage had been discontinued; however, staff reported the alarms were broken and when the program divisional director got a replacement, staff again utilized the chair alarm.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22 (1) and 69.22 (2) and shall be designed to meet the specific needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26 (1))

F. Food Service

Complaint/Incident Allegation: 39691-C It was alleged food portions were too small, and tenants were losing weight. It was alleged snacks were not available for tenants in the dementia unit.

- Monitoring Observation: Three staff members were interviewed. Staff #5, #6, and #7 stated the Program has never run out of food. Tenants can have "seconds" or larger portions, and food was given upon request or complaint of hunger. Staff #6 stated tenants tell her they are always full.

  The kitchen manager was interviewed. She stated the same menu was served in both the secured dementia unit as well as the assisted living. Staff members know the refrigerator is unlocked and extra food was always available, especially to tenants in the secured dementia unit. The kitchen manager stated the Program has never run out of food. Tenant weights were monitored.

  The kitchen manager provided copies of menus signed by a dietitian. The noon meal was observed on 7-10-12. The menu for the day was followed.

  In the tenant meeting, the tenants reported they got enough to eat. The tenants reported they could ask more food if they wanted it.

The Program kept a notebook of the monthly record of vital signs and weights for all current tenants in the building. The notebook was reviewed. Fifteen tenants gained weight in the last three months. Four tenants had documented weight loss, one of which was Tenant #5, who was under hospice care. The monthly records contained the initials of the nurse.

Tenant #5 had a documented two pound weight loss in the last three months. During interview, Staff #5 and #6 stated Tenant #5 ate well but was slow to eat.

The clinical record for Tenant #7 was reviewed. Tenant #7, an 85 year-old, was admitted on 8-17-03 and had diagnoses of: Dementia, Diabetes Mellitus, Parkinson's Disease, Gastritis, HTN, and Depression. Tenant #7 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #7 resided in the assisted living portion of the program that was dementia-specific by definition. According to the service plan, Tenant #7 was independent with eating. The monthly record of weight indicated Tenant #7 gained three pounds in the past three months.

Tenant #10, a 90 year-old, was admitted on 12-28-08 and had diagnoses of: Depressive Disorder, Alzheimer's Dementia, Hypothyroidism, Coronary Artery Disease, HTN, Irritable Bowel Syndrome, and Osteoarthritis. Tenant #10 was staged at six on the GDS which indicated severe cognitive decline. Tenant #10 resided in the secured dementia unit and was admitted to hospice on 4-27-12 with Alzheimer's Dementia and a Urinary Tract Infection. Tenant #10 died on 5-10-12. The service plan indicated Tenant #10 had been on the nutrition intervention protocol to increase calories and protein with each meal.

- Regulatory Insufficiency: None noted.

During the course of the recertification survey, the following information was identified.

G. Dementia-Specific Education

- Monitoring Observation: Staff #8 and #9 were employed by a staffing agency and contracted to work at the program. Review of personnel files revealed both employees had only 4.5 hours of dementia specific training.

  The staffing agency provided documentation that they had provided a staff member for 106 shifts since 4-4-12. The staffing agency stated they were not aware of the requirement for eight hours of dementia training required for assisted living staff of dementia specific programs and they had not provided the training for their staff.

  The program divisional director stated that she did not have the personnel records for staffing personnel at the program but obtained the records at the request of the monitor.

- 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))