IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
CERTIFIED
Complaint Intake #: 41110-C

November 16, 2012

Ms. Mary Keen, 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. Keen:

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: Tenant Rights and Staffing.

Bickford Cottage of Urbandale is being assessed a $2,000 civil penalty pursuant to Iowa Code section 231C.14(1)(a)(b) and 481 IAC 67.12(3)(a)(1)(2). 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. Program failed to provide pain control for a tenant receiving hospice services. The Program failed to comply with regulatory requirements 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 to the health, safety, or security of tenants. Program had repeated regulatory insufficiencies in the area of Staffing.

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 one thousand three hundred dollars ($1300) 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 $2,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on November 16, 2012, has been reviewed and will constitute the final POC related to the on-site visit of October 9, 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:

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

Complaint/Incident Intake #:

41110-C

Date of Complaint/Incident Investigation:

October 9, 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:	11
Number of tenants with cognitive disorder:	16
Total Population of Program at time of on-site	27

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	10
Total Population of Program at time of on-site	10
TOTAL census of Assisted Living Program	37

Program History – The program received regulatory insufficiencies in the areas of: Medications, Service Plan and Dementia Specific Education during the Recertification, Complaint (39691-C) and Incident (39501-I) Investigation of July 10 and 11, 2012. During the August 20, 2012 Incident Investigation (40147-I), the program received regulatory insufficiencies in the areas of Policies and Procedures and Structural.

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 the program did not provide services which met the needs of hospice tenants residing at the program.

- Monitoring Observation: The program identified one tenant currently receiving hospice services (Tenant #1). Tenant #1, a 93 year old, was admitted to the program on 4-22-08 with diagnoses of: Atrial Fibrillation, Alzheimer's Disease, Hypertension, Osteoarthritis, Macular Degeneration and Chronic Pain. Tenant #1 was admitted to hospice services on 7-30-10 with the diagnosis of General Debility. Tenant #1 scored a 3 on the Global Deterioration Scale (GDS), completed on 7-2-12, indicating mild dementia.

  According to the service plan, dated 7-2-12, Tenant #1 exhibited general weakness and shortness of breath with exertion. Tenant #1 was able to make his/her needs known to staff members, could eat independently, required assistance with bathing, hygiene and dressing. Tenant #1 required assistance of one staff to pivot transfer and ambulate, could self propel when in a wheelchair and had only occasional

incontinence of bowel. The program provided assistance with Tenant #1's medication administration.

On 9-6-12, Tenant #1 began to rapidly decline. Tenant #1 began to require assistance with eating, required assistance of two staff members to transfer and ambulate and began experiencing incontinence of bladder and bowel, requiring the use of incontinence briefs. Tenant #1 began spending more time in bed and exhibited a pressure sore on the coccyx. On 9-13-12, the program noted Tenant #1 began experiencing difficulty swallowing. The physician ordered a soft diet with ground meat. The program provided this diet to Tenant #1 but the difficulty swallowing worsened. On 9-14-12, the physician changed the diet to puree with liquids thickened to honey consistency (honey-thickened liquids). Hospice began providing hospice aide services five times weekly and the hospice nurse visited three times weekly.

Tenant #1 rapidly declined between 9-14-12 and 10-9-12. Tenant #1 was currently bedbound, required frequent repositioning by staff members, frequent oral care and incontinence care every two hours, required bed baths and was completely dependent with all activities of daily living. On 10-8-12, Tenant #1 stopped taking in all food and fluids, began vomiting brown/green excrement and had a pulse oxygen reading of 92% on room air. Tenant #1 became non-responsive to verbal stimuli and no longer opened his/her eyes when addressed by familiar hospice staff and program staff members. The physician discontinued all oral medications and initiated the use of Roxanol (liquid morphine) every two hours as needed for pain. The physician ordered oxygen at two liters per nasal cannula to be continuously administered.

Between 9-14-12 and 10-9-12, Tenant #1's upper and lower extremities had decreased in range of motion with contractures beginning to form in his/her bilateral arms and legs. Tenant #1's urine output had been minimal and his/her skin breakdown had increased to include pressure sores to both heels, the outside of the right foot, the outside of the right knee and the right hip. On 10-9-12, Tenant #1 began running a low grade temperature and his/her pulse rate had increased to 100. Tenant #1 did not open his/her eyes or respond verbally. Tenant #1 responded by moaning when staff members repositioned him/her. Tenant #1 appeared to be transitioning with expected death imminent.

During interview, the hospice nurse questioned if staff had been turning Tenant #1 every two hours due to the increase in pressure sores, questioned if staff had been providing oral care every two hours as very few oral swabs, brought by hospice for tenant use, had been used and questioned if staff were identifying non-verbal symptoms of pain as the Roxanol ordered on an as needed basis had not been given.

Staff members began documenting on task sheets beginning on 9-13-12. The task sheets documented repositioning every two hours, performance of oral care every two hours and checking for incontinence every two hours. The monitor interviewed Staff #1, #2, #3, #4, #5, #6, #7 and #8. All reported repositioning Tenant #1, providing oral care and checking for incontinence at least every two hours for the previous three week period.

During interview, the program RN reported she had replaced program purchased oral swabs when the swabs brought by the hospice were used.

Tenant #1 had been taking Oxycontin 20 milligrams routinely three times daily with Oxycodone 10 milligrams given every four hours as needed for pain. On 10-8-12 Tenant #1's physician discontinued all of Tenant #1's oral medications, including the Oxycontin and the Oxycodone. On 10-8-12, the physician ordered Roxanol 10 milligrams per 0.5 milliliters to be given sublingually every two hours as needed for pain. According to medication sheets and interview with the hospice nurse and the program RN, the Roxanol arrived at approximately 6:30 p.m. The hospice nurse and the program RN administered the initial dose of Roxanol at approximately 7:00 p.m.

Staff #5, certified medication aide (CMA), reported checking on Tenant #1 on 10-8-12 at around 9:00 p.m. Tenant #1 was lying in bed with eyes closed and did not awaken with verbal stimulation. Staff #5 did not give the Roxanol as Tenant #1 was "sleeping".

Staff #8, certified nurse aide (CNA), reported working the evening shift on 10-8-12 and stayed working for the 10 p.m. to 6 a.m. shift. Staff #8 reported working with Tenant #1 every two hours, repositioning, providing oral care and checking for incontinence. Staff #8 reported Tenant #1 did not respond verbally and kept eyes closed throughout the shift. Staff #8 reported Tenant #1 moaned with each repositioning. Staff #8 reported she told Staff #6 of Tenant #1's moaning with movement.

Staff #6, CMA, reported working the night shift, taking over from Staff #5 at 10:00 p.m. on 10-8-12. Staff #6 reported Tenant #1 slept the entire shift, observed with eyes closed and respirations easy. Staff #6 reported Tenant #1 did not respond to verbal stimuli. Staff #6 did not administer Roxanol to Tenant #1 during the night shift.

On 10-9-12 at approximately 9:00 a.m. the monitor observed Tenant #1 lying in bed with eyes closed. The hospice aide was in the room with Tenant #1. The hospice aide showed the monitor Tenant #1's pressure areas. Tenant #1 opened his/her eyes, raised his/her head off of the bed and loudly moaned with any touch by the hospice aide. The monitor told the program RN and the program RN had Staff #3, CMA, administer Roxinol.

Tenant #1 was transitioning to end of life with no response to verbal stimuli, kept eyes closed continuously and became bedbound beginning on 10-8-12. End of life pressure ulcers are common and could not be attributed to inadequate repositioning. Adequate oral care was completed per task sheets.

Tenant #1 showed non-verbal indicators of pain throughout the night of 10-8-12 and in the morning of 10-9-12. According to medication administration records, Tenant #1 did not receive any Roxanol between 7:00 p.m. on 10-8-12 until 10:00 a.m. on 10-9-12. Staff members did not administer the Roxanol as needed to assure adequate pain control.

- Regulatory Insufficiency: All tenants have the right to receive care, treatment and services which are adequate and appropriate. (IAC r. 481-67.3(2))

B. Staffing

Complaint/Incident Allegation: It was alleged staff members were not delegated to thicken liquids, administer sublingual medications or to identify symptoms of pain in non-verbal tenants.

- Monitoring Observation: On 9-6-12, Tenant #1, a hospice patient, began to rapidly decline. Tenant #1 began to require assistance with eating, required assistance of two staff members to transfer and ambulate and began experiencing incontinence of bladder and bowel, requiring the use of incontinence briefs. Tenant #1 began spending more time in bed and exhibited a pressure sore on the coccyx. On 9-13-12, the program noted Tenant #1 began experiencing difficulty swallowing. The physician ordered a soft diet with ground meat. The program provided this diet to Tenant #1 but the difficulty swallowing worsened. On 9-14-12, the physician changed the diet to puree with liquids thickened to honey consistency (honey-thickened liquids).

  During interview, the Kitchen Manager reported Tenant #1 received a pureed diet with liquids thickened to honey consistency for approximately three weeks. The Kitchen Manager showed the monitor a can of Thick It, a dry thickener. The Kitchen Manager reported she did not thicken Tenant #1's liquids in the kitchen but all liquids were thickened by staff members prior to assisting Tenant #1 with eating.

  During interview, Staff #3 and Staff #4 reported they were shown by other direct care staff members how to thicken Tenant #1's liquids. Both denied being shown by the RN or completing a return demonstration for the RN to determine competency with the thickening of Tenant #1's liquids.

  During interview, the RN verified she had not completed delegation of any staff members for thickening of Tenant #1's liquids.

  Tenant #1 rapidly declined between 9-14-12 and 10-9-12. Tenant #1 was currently bedbound, required frequent repositioning by staff members, frequent oral care and incontinence care every two hours, required bed baths and was completely dependent with all activities of daily living. On 10-8-12, Tenant #1 stopped taking in all food and fluids, began vomiting brown/green excrement and had a pulse oxygen reading of 92% on room air. Tenant #1 became non-responsive to verbal stimuli and no longer opened his/her eyes when addressed by familiar hospice staff and program staff members. The physician discontinued all oral medications and initiated the use of Roxanol every two hours as needed for pain. Tenant #1 appeared to be transitioning with expected death imminent.

  Tenant #1 had been taking Oxycontin 20 milligrams routinely three times daily with Oxycodone 10 milligrams given every four hours as needed for pain. On 10-8-12 Tenant #1's physician discontinued all of Tenant #1's oral medications, including the

Oxycontin and the Oxycodone. On 10-8-12, the physician ordered Roxanol 10 milligrams per 0.5 milliliters to be given sublingually every two hours as needed for pain. According to medication sheets and interview with the hospice nurse and the program RN, the Roxanol arrived at approximately 6:30 p.m. The hospice nurse and the program RN administered the initial dose of Roxanol at approximately 7:00 p.m.

Staff #5, CMA, reported checking on Tenant #1 on 10-8-12 at around 9:00 p.m. Tenant #1 was lying in bed with eyes closed and did not awaken with verbal stimulation. Staff #5 did not give the Roxanol as Tenant #1 was "sleeping". Staff #5 reported the program RN simulated administration of a liquid sublingually by drawing up water in a syringe and administering the water sublingually. Staff #5 verified the RN did not observe Staff #5 giving the Roxanol to Tenant #1 prior to leaving for the night at around 8:30 p.m.

Staff #8, CNA, reported working the evening shift on 10-8-12 and stayed working for the 10 p.m. to 6 a.m. shift. Staff #8 reported working with Tenant #1 every two hours, repositioning, providing oral care and checking for incontinence. Staff #8 reported Tenant #1 did not respond verbally and kept eyes closed throughout the shift. Staff #8 reported Tenant #1 moaned with each repositioning. Staff #8 reported she told Staff #6 of Tenant #1's moaning with movement.

Staff #6, CMA, reported working the night shift, taking over from Staff #5 at 10:00 p.m. on 10-8-12. Staff #6 reported Tenant #1 slept the entire shift, observed with eyes closed and respirations easy. Staff #6 reported Tenant #1 did not respond to verbal stimuli. Staff #6 did not administer Roxanol to Tenant #1 during the night shift. Staff #6 reported Staff #5 told her how to give the Roxanol to Tenant #1 at shift change. Staff #6 verified that the program RN did not delegate her to administration of sublingual medications.

On 10-9-12 at approximately 9:00 a.m. the monitor observed Tenant #1 lying in bed with eyes closed. The hospice aide was in the room with Tenant #1. The hospice aide showed the monitor Tenant #1's pressure areas. Tenant #1 opened his/her eyes, raised his/her head off of the bed and loudly moaned with any touch by the hospice aide. The monitor told the program RN and the program RN had Staff #3, CMA, administer Roxinol. Staff #3 had been working since 6:00 a.m. and was not delegated by the RN until 10:00 a.m. on 10-9-12.

The personnel files of Staff #3, #5 and #6 lacked documentation of delegation to administer sublingual medications.

During interview, the program RN verified she had not completed delegations for the administration of Tenant #1's Roxanol sublingually with the exception of Staff #3. The RN concurred she did not delegate Staff #3 until part way through Staff #3's shift by which she may have had to administer the Roxanol on an as needed basis every two hours.

The program RN did not delegate Staff #3 or Staff #4 to assure each was competent to thicken Tenant #1's liquids to the appropriate consistency. The program RN did not delegate Staff #3, Staff #5 or Staff #6 to assure each was competent to administer Tenant #1's Roxinol as ordered by the physician despite the possibility that each may

need to administer the medication on an as needed basis. Tenant #1 was transitioning to end of life with no response to verbal stimuli, kept eyes closed continuously and became bedbound beginning on 10-8-12. Tenant #1 showed non-verbal indicators of pain throughout the night of 10-8-12 and in the morning of 10-9-12. Staff members had not always identified the non-verbal indicators of pain expressed by Tenant #1.

- 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. Food Service

Complaint/Incident Allegation: It was alleged the program's dietician did not approve menus to be served to tenants receiving therapeutic diets.

- Monitoring Observation: Initially the program RN and the Kitchen Manger reported the program only had menus for a general diet. Both concurred Tenant #1's diet changed to puree with liquids thickened to a honey consistency recently. Later, the monitor was presented with recipes for pureed food items and menus signed by the program's consultant dietician.

- Regulatory Insufficiency: None noted.