IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 40913-I

November 19, 2012

Ms. Debby Cooper, Administrator
Bickford Cottage Marshalltown
101 New Castle
Marshalltown, IA 50158

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

Dear Ms. Cooper:

I. Final Complaint/Incident Investigation Report – Bickford Cottage Marshalltown, Marshalltown, 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: Nurse Review, Staffing and Tenant Documents.

Bickford Cottage Marshalltown is being assessed a $5,000 civil penalty pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.12(3)(a)(1). 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 violated regulations which resulted in harm to a tenant.

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 to the State of Iowa in the amount of three thousand two hundred and fifty dollars ($3250) 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 $5000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on November 14, 2012, has been reviewed and will constitute the final POC related to the on-site visit of September 27 and October 1, 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, 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:

Bickford Cottage Marshalltown
Debby Cooper, Administrator
101 New Castle
Marshalltown, IA 50158

Complaint/Incident Intake #:

#40913-I

Date of Complaint/Incident Investigation:

September 27 and October 1, 2012

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.

Dementia-Specific Program by Definition	
Number of tenants without cognitive disorder:	33
Number of tenants with cognitive disorder:	5
Total Population of Program at time of on-site	38
TOTAL census of Assisted Living Program	38

Program History – The Program received regulatory insufficiencies in the area of Medications during this certification period.

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

A. Nurse Review

Complaint/Incident Allegation: The program reported a tenant fell, sustained a head injury and subsequently died.

- Monitoring Observation: The monitors reviewed clinical records of Tenant #1, #2 and #3 all of which sustained falls. No problems were identified with Tenant #1 or #2. Tenant #3, an 89 year old, was admitted on 3-11-12 with diagnoses of: Hypertension, Dementia, Glaucoma, Osteoarthritis, Renal Artery Stenosis, Hyperlipidemia, and Rheumatoid Arthritis. Tenant #3 scored 4 on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. The service plan of 8-16-12 documented Tenant #3 utilized a wheeled walker and gait belt with stand by assistance of one staff person. Tenant #3 required assistance with bathing, grooming, and dressing. Tenant #3 was to be toileted every two hours to prevent attempts to transfer independently. The program used a personal pad alarm at all times to alert staff to Tenant #3 independent movement. Tenant #3 was independent with eating and required assistance only to open packets and cutting up food.

  An incident report dated 9-9-12 at 3:15 p.m. indicated staff members responded to an alarm finding that Tenant #3 fell while attempting to transfer independently. The fall resulted in a head injury with bruising at the left upper forehead and left cheekbone. The employee on staff notified the Registered Nurse (RN) immediately. The RN instructed staff to apply ice to the bruise and initiate neurological checks to be completed every 15 minutes for one hour and then hourly for four hours and then every four hours for 24 hours. The RN assessed Tenant #3 at 10:00 a.m. on 9-10-12 and then notified the physician via facsimile at 12:25 p.m.

An incident report dated 9-12-12 at 3:05 a.m. documented that staff members responded to an alarm and found that Tenant #3 had fallen. Staff #1, a Licensed Practical Nurse, (LPN) assessed Tenant #3 who complained of back and shoulder pain. Staff #1 found no evidence that Tenant #3 hit his/her head. Staff #1 called the RN at 3:25 a.m. and was advised to monitor the tenant. During interviews, Staff #1 LPN, Staff #2 Certified Medication Aide (CMA), Staff #3 CMA, Staff #4 LPN and Staff #5 Certified Nurse Aide (CNA) stated Tenant #3 had no changes in condition during the morning, afternoon and evening hours of 9-12-12. The physician was not notified at this time regarding the fall.

During interview, Staff #1 stated that approximately 6:30 a.m. on 9-13-12, Tenant #3 was moving very slow and reported back pain but Staff #1 thought the slowness was due to the back pain. Staff #1 used a wheelchair to take Tenant #3 to the dining room. Staff #1 noticed then that Tenant #3's speech was broken and slow. Staff #1 did not report these findings to anyone.

Staff #3 reported Tenant #3 had difficulty understanding directions to swallow medications and had difficulty understanding words at approximately 8:30 a.m. on 9-13-12. Staff #3 reported this to the RN.

The RN completed an assessment at 10:00 a.m. on 9-13-12 and identified a new red purple bruise around the right eye. The RN documented Tenant #3 denied pain and ambulated without difficult, was oriented per usual and no change was noted in functional or cognitive abilities.

At approximately 11:00 a.m. Staff #6, CMA, assisted Tenant #3 to his/her apartment to toilet. Tenant #3 was very weak and could not stand. Staff #6 had Tenant #3 sit on the walker seat and pushed him/her to transport to the apartment. Staff #6 took Tenant #3 to the dining room and noted that Tenant #3 seemed lethargic. Staff #6 reported that to the RN.

At around noon, Staff #3 reported noting Tenant #3 playing in his/her food, pouring liquids onto the table, speech was garbled and Tenant #3 had to be fed lunch. Staff #5 also noted at noon on 9-13-12, Tenant #3 could not hold a fork dropping it on the floor multiple times and was attempting to use a spoon up-side-down. Staff #5 asked Tenant #3 if he/she was OK and Tenant #3 responded, "I don't know." Tenant #3's verbal responses were unusual for that tenant. At this time staff members took Tenant #3 by wheelchair to his/her apartment.

The RN documented on 9-13-12 at 12:15 p.m. Tenant #3 was having difficulty with ambulation and lifting his/her feet, had increased weakness, difficulty of coordination lifting a glass to drink and as not responding to verbal statement as usual. Tenant #3's blood pressure was 200 over 82. The RN left a message with Tenant #3's Durable Power of Attorney (DPOA) but did not contact the physician. At 12:25 p.m. the RN documented Tenant #3's blood pressure had increased to 210 over 100. She attempted to contact the DPOA again but did not get a response so she contacted the alternate DPOA and gave him/her an update. The alternate DPOA planned to contact the physician. The RN did not call the physician. At 2:30 p.m. on 9-13-12 the RN faxed the physician reporting that Tenant #3 fell on 9-12-12.

The fax noted Tenant #3's range of motion was within normal limits, the tenant complained of generalized pain and discomfort, the tenant was having difficulty with ambulation and not responding verbally to staff per usual. She did not indicate Tenant #3 had hit his/her head nor did she address the garbled speech or difficulty with fine motor skills (holding utensils) or having to be fed. At 3:00 p.m. the RN charted that she noted slurred speech. The physician telephoned the RN and was given an update. The RN reported a blood pressure of 184 over 96 and slurred speech but did not report to the physician regarding the head injury. The physician wanted to check with the pharmacy regarding medications and was going to return the call. At 3:30 p.m., the physician called and questioned if Tenant #3 had been given Cardura (blood pressure medication) as ordered because the DPOA who prefilled Tenant #3's medication planner had not filled the prescription for the last several days. The physician indicated the slurred speech could be a result of the high blood pressure and recommended monitoring with a call in morning.

Staff #7, CMA, reported checking on Tenant #3 at 3:00 p.m. on 9-13-12. She noted confusion and slurred speech. Staff # 7 took vital signs and reported to the RN. At around 4:00 p.m. Staff #7 took Tenant #3 to the dining room where the tenant poured orange juice on the table.

Staff #2 reported working second shift on 9-13-12. She stated that at 4:00 p.m. she noted Tenant #3 had slurred speech and was unable to get the words out. Tenant #3 couldn't comprehend what staff members were saying. At approximately 4:30 p.m. Staff #2 observed Tenant #3 pouring liquids all over the table. Staff #2 notified the RN.

The above statements from staff were reported to be different from usual behavior for Tenant #3.

The RN reported she left the program on 9-13-12 at approximately 5:00 p.m.

At approximately 6:00 p.m., the alternate DPOA came to the program and visited Tenant #3 until 6:45 p.m. The alternate DPOA called the DPOA and physician. The physician talked to the CMA and advised her to transport Tenant #3 to the emergency room. The ambulance arrived on 9-13-12 at 6:51 p.m.

The physician stated he did have conversations with Tenant #3's family and the RN. The physician did not know Tenant #3 had a head injury and was concentrating on the blood pressure and medications. The physician did not know the full extent of the changes until the family member called at 6:30 p.m. The physician reported Tenant #3 had a signed Do Not Resuscitate request and family members chose to provide comfort care only with no medical intervention. The physician believed that with these circumstances the outcome would not have been different if notified earlier.

The RN assessed Tenant #3 at 10:00 a.m. noting new bruising to the right eye. Multiple staff members reports changes in Tenant #3's cognitive and functional status. The RN did not notify the physician of her determination that Tenant #3 had hit his/her head.

The physician concentrated on the high blood pressures and medication lapse instead of the correlating the high blood pressures to a potential head injury. The RN left the program and did not continue to monitor Tenant #3's progress with the changes in the tenant's health status.

- Regulatory Insufficiency: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

During the course of the investigation, the following information was identified:

B. Staffing

- Monitoring Observation:

  An incident report, dated 9-9-12 at 3:15 p.m., indicated staff members responded to an alarm sounding, to find Tenant #3 on the floor in his/her apartment. Tenant #3 reported falling while attempting to transfer independently. The fall resulted in a head injury with bruising at the left upper forehead and left cheekbone. The employee on staff notified the Registered Nurse (RN) immediately. The RN instructed staff to apply ice to the bruise and initiate neurological checks to be completed every 15 minutes for one hour and then hourly for four hours and then every four hours for 24 hours.

  The Neurological Flow Sheet indicated Staff #4, #6 and #7 completed Tenant #3's neurological checks. Staff #4 and #5's personnel records included documentation of nurse delegation for tenant care following a fall with head injury. Neurological checks were included in the training for falls with head injury. The RN determined Staff #4 and #5 were competent to perform neurological checks.

  Staff #7's personnel file lacked documentation of completion of the delegation for tenant care following a fall with head injury. Staff #7 completed Tenant #3's neurological checks on 9-9-12 eleven times without delegation to determine competency to perform the task.

- 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))

B. Tenant Documents

- Monitoring Observation: After review of Tenant #3's clinical record, the monitors noted discrepancies between nurses' notes, completed by the program RN, documentation of ambulance response reports and staff member interviews. The nurses' notes contained multiple entries written by the program RN which were initially dated 9-14-12. The dates had been overwritten, changing the date to 9-13-12.

The nurses' notes reflected a time line that varied from staff member interviews and the ambulance response report for Tenant #3's deterioration in health status, which resulted in a need for transfer to the emergency room via ambulance for medical evaluation. The RN told the monitors she documented multiple entries in Tenant #3's clinical record on 9-14-12 without indicating the documentation was a late entry and without verifying the exact time of occurrence for each entry prior to documentation. The monitors noted seven entries which included overwritten dates or incorrect times of occurrence. Documentation in Tenant #3's clinical record was not reflective of the actual occurrence of events.

- Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy and medication; and nurses' notes written by exception when any personal or health- related care is delegated to the program. (IAC r. 481-69.25(1)i)