IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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DEMAND LETTER
CERTIFIED
Complaint Intake #: 43871-I

July 15, 2013

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

RE: **I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - BICKFORD COTTAGE OF URBANDALE**
II. Reduction of 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 ("Report")** issued 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, following an investigation by DIA on **June 4, 2013.** The Report notes Regulatory Insufficiency in the area(s) of: Criteria for Admission and Retention.

Bickford Cottage of Urbandale ("Program") is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.12(3)(a)(1).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.12(3)(a)(1), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.12(3)(b) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The determination of a **$500 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, a tenant fell approximately 12 times in 4 months. One of the falls resulted in a radial ulnar fracture.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service 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 **three hundred and twenty five dollars ($325)** within 30 days after the notice or service of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision within thirty (30) days of the notice or service of this demand letter by submitting a written 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 the notice or service of this demand letter.

IV. Conclusion

The Program is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.12(3)(a)(1). The Plan of Correction (POC) submitted on July 15, 2013, has been reviewed and will constitute the final POC related to the on-site visit of June 4, 2013.

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 notice or service 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,

Jim Friberg

Jim Friberg, Acting 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 #:

43871-I

Date of Complaint/Incident Investigation:

June 4, 2013

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.

General Population Program	
Number of tenants without cognitive disorder:	32
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	35
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	14
Total Population of Program at time of on-site	14
TOTAL census of Assisted Living Program	49

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. The program received regulatory insufficiencies in the areas of Tenant Rights and Staffing during the October 9, 2012 Complaint Investigation (41110-C).

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

Criteria for Admission and Retention

Complaint/Incident Allegation: It was reported a tenant fell multiple times which at times resulted in injury.

- Monitoring Observation: The monitor reviewed the program's incident reports from the previous three month period, noting Tenants #1, #2 and #3 experienced multiple falls which at times resulted in injury.

  Tenant #2 resided in the memory care unit and experienced three falls in March and April 2013, with one fall resulting in a skin tear that did not require medical evaluation. Tenant #3 resided in the memory care unit and experienced four falls in March, April and May 2013, with two of the falls resulting in a skin tear that did not require medical evaluation. Neither tenant had experienced any falls for greater than 30 days. Both tenants now required staff member assistance with transfers and ambulation.

Tenant #1, a 90 year old, was admitted to the program on 12-13-11 with diagnoses of: Alzheimer's Disease; Depression, Diabetes, Hypertension and Vitamin B12 deficiency. Tenant #1 resided in the memory care unit. Tenant #1 scored a 5 on the Global Deterioration Scale completed on 5-30-13, indicating moderately severe cognitive decline.

Tenant #1's clinical record indicated he/she fell on 12-11-12, resulting in no injury. Tenant #1 fell on 1-6-13 at 10:35 p.m., resulting in a facial skin tear and fell on 2-8-14 at 5:30 a.m., 2-17-13 at 7:00 p.m. and 2-27-13 at 7:00 p.m., resulting in no injury. The service plan, dated 3-6-13, indicated Tenant #1 was independent with transfers and ambulation, using a four wheeled walker, and was independent with toileting.

Tenant #1's clinical record indicated he/she fell on 3-25-13 at 1:50 p.m., resulting in no injury. Tenant #1 fell on 4-16-13 at 5:00 p.m., resulting in multiple skin tears on his/her arms and fell on 5-7-13 at 6:45 p.m., resulting in a radial and ulnar fracture (both bones located in the forearm). Tenant #1's right forearm was casted on 5-7-13. The service plan, completed on 5-9-13, indicated Tenant #1 remained independent with transfers and ambulation using a four wheeled walker following the arm fracture. The service plan directed staff members to assist Tenant #1 with toileting before and after meals and at bed time until the arm cast was removed.

Tenant #1's clinical record indicated he/she rolled out of bed onto the floor on 5-11-13 at 10:25 a.m., receiving no injury, fell on 5-15-13 at 4:30 p.m., resulting in a skin tear to the shin, and fell on 5-17-13 at 1:45 p.m., resulting in no injury. The service plan, completed on 5-21-13, documented Tenant #1 began receiving physical therapy visits to assist with strength training to decrease falls.

Physical therapy notes indicated the therapist moved Tenant #1's bed location in his/her apartment to better facilitate getting in and out of bed independently without resulting in falls on 5-23-13. The therapist also, on 5-23-13, built up the right hand grip on Tenant #1's walker with a washcloth due to Tenant #1's inability to effectively grasp the walker due to the placement of the arm cast.

Tenant #1's clinical record indicated he/she fell on 5-22-13 at 1:00 a.m., resulting in no injury, fell out of bed on 5-28-13 at 11:50 p.m., resulting in no injury, and fell on 5-29-13 at 4:15 a.m., resulting in skin tears to the left hand. The service plan, completed on 5-30-13, indicated the program initiated the use of a bed alarm to notify staff members when Tenant #1 was getting out of bed so staff members could supervise the transfer and ambulation during the night.

During the on-site visit on 6-4-13, the monitor observed no washcloth built up on Tenant #1's walker grip. During interview, Staff #1, certified nurse aide (CNA), and Staff #2, certified medication aide (CMA), both reported Tenant #1 did not like how the washcloth placed on the walker by the therapist and removed it. Both staff members reported Tenant #1 also had ripped apart one cast which had to be replaced. The monitor observed Tenant #1 walk across the common area of the secured memory care unit using the walker. Tenant #1 was not able to fully grasp the right walker grip as the cast caused Tenant #1's hand to be elevated to a height that prevented adequate grip.

During interview, Staff #1 and Staff #2 both reported Tenant #1's right hand and fingers were swollen, preventing the fingers to bend at all for approximately three weeks. The swelling progressively went down, allowing for bending of the fingers but both staff members concurred Tenant #1 had not been able to fully grip the walker with the right hand due to the placement of the cast.

Tenant #1 experienced multiple falls resulting in minor injuries prior to the fall on 5-7-13, which resulted in the fracture of Tenant #1's right forearm. Since the fracture, Tenant #1 had fallen six more times, with two of the falls resulting in minor injuries, despite interventions put into place to prevent further falls. Tenant #1's cognitive status prevented Tenant #1 from effectively reasoning the need for the added interventions and prevented Tenant #1 from identifying the need to call for staff member assistance with transfers or ambulation. Tenant #1 exceeded the level of care allowed for an assisted living program as he/she experienced 12 falls in a four month period, some resulting in injuries to Tenant #1.

- 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))