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 #: 44257-C

July 31, 2013

Ms. Sarah Akers, Director
Bickford Cottage Marion
1100 Linden Drive
Marion, IA 52302

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - BICKFORD COTTAGE MARION
II. Reduction of Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Akers:

I. Final Complaint/Incident Investigation Report – Bickford Cottage Marion, Marion, 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 **July 9, 2013.** The Report notes Regulatory Insufficiency in the area(s) of: Criteria for Admission and Retention.

Bickford Cottage Marion ("Program") is being assessed a **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2).

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.12(3)(a)(2), the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

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 Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received a Regulatory Insufficiency in the area of Criteria for Admission and Retention.

The determination of a **$1,000 civil penalty** is based upon repeated Regulatory Insufficiency in the area(s) of: Criteria for Admission and Retention. As the enclosed Report details, the Program retained a tenant who exceeded level of care criteria. The tenant was a danger to self and others by being physically aggressive. The tenant also had unmanageable incontinence.

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 **six hundred fifty dollars ($650)** 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 **$1,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.12(3)(a)(2). The Plan of Correction (POC) submitted on July 23, 2013, has been reviewed and will constitute the final POC related to the on-site visit of July 9, 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:

Bickford Cottage Marion
Sarah Akers, Director
1100 Linden Drive
Marion, IA 52302

Complaint/Incident Intake #:

44257-C

Date of Complaint/Incident Investigation:

July 9, 2013

Monitor(s):

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:	9
Number of tenants with cognitive disorder:	13
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:	7
Total Population of Program at time of on-site	7
TOTAL census of Assisted Living Program	29

Program History – The Program received a regulatory insufficiency in the area of staffing during the October 18, 2011 Recertification visit. During the February 27 and 28, 2012 Complaint Investigation (37713-C) the Program received a regulatory insufficiency in the area of medications. During the May 24, 2012 Incident Investigation (39084-I) the Program received a regulatory insufficiency in the area of staffing. During the January 8 and 9, 2013 Complaint Investigation (41775-C), the Program received regulatory insufficiencies in the areas of Criteria for Admission and Retention and Service Plan.

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

Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged a tenant exceeded the level of care criteria for assisted living.

- Monitoring Observation: Three clinical records were reviewed. Tenant #1 and #3 did not exceed level of care criteria of assisted living.

Tenant #2, an 88 year old, was admitted to the secured memory care unit on 2-7-13 with a diagnosis of Dementia. Tenant #2 scored six on the Global Deterioration Scale (GDS) dated 6-6-13 which indicated severe cognitive decline.

The clinical record contained the following documentation of behaviors:

1. 2-10-13 Tenant refused to toilet during the night. Became very agitated and tried to pull staff into the bed. Staff got assistance and Tenant #2 began kicking.
2. 3-29-13 Tenant very combative so staff was unable to complete cares.
3. 4-1-13 Tenant combative with cares. Three attempts made to complete cares.
4. 5-20-13 Tenant refused cares. Took three staff to assist and complete.

5. 5-25-13 Tenant received a skin tear on the right hand which occurred while being combative with staff while staff attempted to perform patient cares.
6. 5-26-13 Tenant tried to hit staff. Were able to get cares done after several attempts.
7. 5-30-13 Tenant combative while doing cares that needed to be done.
8. 6-1-13 Tenant combative with cares. Three staff assisted for cares at this time unable to do peri care until this time. Very foul odor.
9. 6-3-13 4:30 p.m. Tenant awake and in other tenant's room trying to physically remove the other tenant from bed. Became very agitated after being redirected to own apartment. Tenant was incontinent of bowel and bladder. Finally took three staff to change him/her. Extremely combative, kicking and trying to bite staff and head butting.
10. 6-3-13 6:30 p.m. Tenant became aggressive and attempted to hit Certified nurse aide (CNA) and grab hold of her wrist. Another tenant approached and Tenant #2 proceeded to attempt to hit that tenant and scare them.
11. 6-6-13 Tenant appears to not understand toileting, to remove pants, and sit on toilet. With too much encouragement Tenant #2 had lashed out refusing assistance.
12. 6-13-13 Tenant entered another apartment incontinent of urine. Trying to sit on other tenant's bed. Redirection unsuccessful until three staff members assisted. Tenant not compliant with p.m. cares. Hit and bit staff member on the shoulder.
13. 7-3-13 4:00 p.m. Tenant came up behind staff with fist balled up and gesturing as if to strike her. Tenant then walked behind a rocking chair where another tenant sat and shook the chair
14. 7-6-13 11:00 p.m. Tenant seeking entry into another tenant's room making numerous attempts to lie down next to the tenant in the bed. Numerous attempts to redirect Tenant #2 failed. Tenant #2 became combative and began swinging fists at staff.
15. 7-8-13 Tenant #2 needed to have soiled depends changed. Assist of three staff to hold tenant still. Tenant was kicking, biting and hitting at all four staff. Later Tenant #2 entered the apartment of another tenant who was sleeping. Tenant #2 began pulling on the other tenant's legs and feet.

Staff #1 reported Tenant #2 often needed repeated redirection for behaviors. Staff #1 had heard other staff report incidents with Tenant #2 swinging at staff and shaking fists. Staff #1 reported Tenant #2 was incontinent of bowel and bladder and resistive to assistance most of the time.

On 7-9-13 at 8:20 a.m. the monitor observed Tenant #2 seated at the dining room table with a family member present. Staff #2 said Tenant #2 often tried to enter other's rooms so one tenant had placed a chair in front of the door to their apartment to deter Tenant #2 from entering.

The Registered Nurse (RN) reported Tenant #2 had been having behaviors for the past couple of months. They had completed staff retraining. Tenant #2 had a physician's appointment but it had been canceled and another appointment could not be set up until 7-26-13. On 7-3-13, the RN had added an intervention to the service plan to have one on one care by family from 8:00 a.m. till noon and home health would schedule some one on one time for later afternoon.

Tenant #2 exceeds level of care criteria for unmanageable incontinence, is a danger to self and others, and displays unmanageable aggression and behavior that places other tenants at risk.

- Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: 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 g. Has unmanageable incontinence on a routine basis despite an individualized toileting program. (IAC r. 481-69.23(1) c. 1 and 2 and g.)