IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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RODNEY A. ROBERTS, DIRECTOR

January 21, 2015

Complaint Intake #: 51262-C
51263-C

Ms. Alice Comer, Director
Bickford Cottage Iowa City
3500 Lower West Branch Road
Iowa City, IA 52245

RE: Final Complaint Investigation & Recertification Monitoring Evaluation Report – Bickford Cottage Iowa City, Iowa City, IA

Dear Ms. Comer:

Enclosed is the **Final Complaint 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) chapters 481—67 and 481—69, following a survey by DIA on **January 5, 6, 7, 8 and 12, 2015.** The following allegations were investigated and unsubstantiated in regards to Complaint #51262-C:

Allegation: Tenant Rights
Findings: Unsubstantiated

Comments: Based on tenant interviews, review of Program records and staff interviews there were no concerns regarding tenant rights. Per staff interviews the television programming in the common living room area was of a lighter nature regarding subject material and violent programming was not shown in the common living room area. The activity room had a television for tenant use and tenants could provide a television in their apartments. Review of the Occupancy Agreement revealed the Program was not required to provide television programming in any of the common areas. Tenant interviews revealed some of the tenants were aware of the preferred nature of the programming in the living area; however, the majority of the tenants did not voice concerns regarding the policy.

The tenants did not voice concerns regarding movies including the movies shown or the times or days the movies were shown. The January 2015 activity calendar reflected movies were shown in the daytime. Observations on several days of the investigation revealed tenants watched television in the living area and also in the activity room. There were no outcomes including falls or incidents related to having tenants watching television or movies in the activity room per staff interview. There were some tenant concerns voiced regarding the placement of the television in the living room and the accommodations of the

watching television in the activity room; however, the complaints were from a few tenants and not the majority of tenants. Review of the Occupancy Agreement revealed the Program was not required to provide any certain accommodations in the living area or activity room for television viewing. Tenant council meetings minutes for the past three months were reviewed and there were no comments or concerns provided regarding the television programming, location of the televisions or accommodations provided in the living area or activity room. On 11-21-14 a tenant and family meeting was held and the television policies and explanation of the change of television locations were reviewed and there was no feedback from those who attended. Per tenant interviews the remote control was made available to tenants. Although there were some complaints regarding the television areas and accommodations the complaints voiced did not meet the standard to determine a regulatory insufficiency exists.

The majority of the tenants interviewed did not voice concerns with retaliation and per one tenant who had a concern regarding retaliation there were no specifics provided related to the concern. The tenant interviews revealed some of the tenants did not feel they could go to the Director; however, they felt they could go to other management staff with concerns. One tenant reported he/she was told if the criticisms did not improve the rates would increase. The two staff alleged to have been present during the conversation denied such a conversation with any tenants and said discussions with tenants were respectful. One of the staff indicated it was impossible to increase rates based on attitudes as it was based on level of care and room size. Staff interviews indicated the tenants had not voiced concerns regarding retaliation. Staff said tenants could present grievances to the Department and to the Long Term Care Ombudsman (LTCO). Staff said there were no concerns with tenant rights, tenants could have conservations with other tenants and tenants were treated respectfully by all staff. The majority of the tenants said they could have conversations with others without fear of reprisal. A concern was shared that a tenant was careful about he/she talked to; however, did not provide specifics. Tenants did not express concerns about meeting with a representative from the Department or the LTCO. Although a few complaints were shared regarding issues with communication and retaliation there were no specifics provided that were rule based as to why the concerns or issues existed and the concerns voiced did not meet the standard to determine a regulatory insufficiency exists.

Regarding pendants the majority of the tenants did not voice concerns regarding the pendants or staff response. Staff interviews revealed tenants had never been told not to use the pendants and pendants were available to tenants. One tenant said he/she was told the pendant was for emergencies only and not to use to for assistance to the restroom. In addition one tenant said he/she was without a pendant for two to three days because the battery needed to be replaced. A staff interview indicated the tenant's pendant was replaced, it was found behind the toilet and it appeared to have a broken band. The tenant reported no falls during that time. The apartments had pull cords which activated to call for staff assistance with one touch. Despite the tenant not having a pendant for an undetermined amount of time, pull cords were available for the tenant call and the tenant was not indicated to have a Global Deterioration Scale of four or greater and could report the missing pendant or call for assistance.

The tenants voiced no concerns with garbage removal including soiled briefs being removed from the apartments. Staff interviews indicated the soiled briefs were removed after staff was finished assisting with the care if they managed the incontinence care for the tenants. The monitor was in the building several days and in and out of several tenant apartments and did note any odors that would be associated with soiled briefs or untimely garbage removal.

Per tenant interviews the cash Bingo prizes were delayed by several weeks. Staff maintained records of the amount owed to tenants. Although tenants mentioned the Bingo prizes were delayed there were no concerns about receiving the money owed. A staff interview indicated a check needed to be cut for the Bingo quarters and the timeframe varied but sometimes it took a couple weeks to receive it. A Program policy for activities was reviewed and there was no mention of the prizes or expectation of time prizes were to be received for activities including Bingo.

The following allegations were investigated and unsubstantiated in regards to Complaint #51263-C:

Allegation: Tenant Rights
Findings: Unsubstantiated

Comments: Based on a staff interview, review of tenant files, Program documents and review of marketing materials there were no concerns with tenant rights. Per a staff interview corporate marketing materials were used for marketing and none of the current tenants at the local branch (Bickford Cottage Iowa City) were used in any marketing materials or marketing campaigns.

Allegation: Staffing
Findings: Unsubstantiated

Comments: Based on seven tenant file reviews and staff interviews there were no concerns with staffing. The tenant files reviewed did not specify restrictions on which staff could take tenants out of the building. Staff interviews did not identify any restrictions or arrangements for specific staff taking tenants out of the building. Per a staff interview there were no outcomes related to tenants and drinking alcohol. Review of tenant files did not reveal any documentation that prohibited the consumption of alcohol.

Allegation: Records
Findings: Unsubstantiated

Comments: Based on seven tenant file reviews, a staff interview and review of Program's documents there were no concerns identified regarding records. The tenant files reviewed had code resuscitation status designations available for review. According to a staff interview during the transition between nurses if some documents could not be found the documents were replaced and there were no missing documents or records at the time of the investigation. The Program provided a policy regarding the order for charts and appeared to follow the policy.

Allegation: Activities/Tenant Rights
Findings: Unsubstantiated

Comments: Based on tenant interviews, review of Program records and staff interviews there were no concerns regarding activities/tenant rights. Per staff interviews the television programming in the common living room area was of a lighter nature regarding subject material and violent programming was not shown in the common living room area. The activity room had a television for tenant use and tenants could provide a television in their apartments. Review of the Occupancy Agreement revealed the Program was not required to provide television programming in any of the common areas. Tenant interviews revealed some of the tenants were aware of the preferred nature of the programming in the living area; however, the majority of the tenants did not voice concerns regarding the policy.

Monitor observations on several days of the investigation revealed tenants watched television in the living area and also in the activity room. There were no outcomes including falls or incidents related to having tenants watching television or movies in the activity room per staff interview. There were some tenant concerns voiced regarding the placement of the television in the living room and the accommodations of the watching television in the activity room; however, the complaints were from a few tenants and not the majority of tenants. Review of the Occupancy Agreement revealed the Program was not required to provide any certain accommodations in the living area or activity room for television viewing. Tenant council meetings minutes for the past three months were reviewed and there were no comments or concerns provided regarding the television programming, location of the televisions or accommodations provided in the living area or activity room. On 11-21-14 a tenant and family meeting was held and the television policies and explanation of the change of television locations were reviewed and there was no feedback from those who attended. Per tenant interviews the remote control was made available to tenants. Although there were some complaints regarding the television areas and accommodations the complaints voiced did not meet the standard to determine a regulatory insufficiency exists.

The Report notes Regulatory Insufficiencies in the area(s) of: Record Checks and Dementia Specific Education for Program Personnel. The regulatory insufficiencies cited were related to the recertification visit and are indicated on the enclosed report.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Also enclosed you will find the Assisted Living Program Certificate **S0023** with effective dates of **December 1, 2014** through **November 30, 2016**.

If you have any questions in regard to this report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0023	A. BUILDING: _____ B. WING _____	C 01/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE IOWA CITY	3500 LOWER W BRANCH RD IOWA CITY, IA 52245

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Definition Number of tenants without cognitive disorder: 25 Number of tenants with cognitive disorder: 6 Total Population of Program at time of on-site: 31 TOTAL census of Assisted Living Program: 31 A recertification visit and two complaints #51262-C and #51263-C were completed. There were no regulatory insufficiencies related to complaints #51262-C and #51263-C. The regulatory insufficiencies cited were related to the recertification visit.	A 000		
A 118	481-67.19(3) Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on staff files, timecard records, a Program	A 118		

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A 118	Continued From page 1 policy and a staff interview the Program failed to complete criminal history background checks and abuse history background checks for two of seven staff (Staff A and B). Two staff members were hired and received paid wages prior to the completion of required background checks. 1. Staff A, a certified nursing assistant (CNA), was hired on 8-25-14. A criminal history background check and abuse registries background check was not completed prior to employment or at the time of the onsite. 2. Staff B, a CNA, was hired on 9-5-14. A criminal history background check and abuse registries background check was not completed prior to employment or at the time of the onsite. 3. According to timecard records, Staff A received paid wages on 8-28-14 and Staff B received paid wages on 9-5-14. 4. According to the Program's policy regarding criminal background checks, the Program would comply with Iowa regulations or guidelines regarding background checks. The offer of hire was contingent upon a criminal background check, dependent adult abuse check and child abuse check, drug test and physical. Training could not begin until the process was favorably completed. 5. According to an interview with the Director on 1-8-15 at 1:20 p.m. the background checks were not found for Staff A and Staff B.	A 118		
A 121	481-69.30(1) Dementia Specific Education for Personnel	A 121		

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A 121	Continued From page 2 481-69.30(231C) Dementia-specific education for program personnel. 69.30(1) 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. This REQUIREMENT is not met as evidenced by: Based on staff files, the ALP Monitoring Entrance Form, a Program policy and a staff interview the Program failed to provide eight hours dementia-specific training within 30 days of employment for six out of seven staff files (Staff A, B, C, D, E and F). The Program was dementia-specific by definition and six staff did not have eight hours of dementia-specific training within 30 days of employment. 1. Staff A, a certified nursing assistant (CNA), was hired on 8-25-14 and did not have eight hours of dementia training within 30 days of employment. 2. Staff B, a CNA, was hired on 9-5-14 and did not have eight hours of dementia training within 30 days of employment. 3. Staff C, a licensed practical nurse, was hired on 10-28-14 and did not have eight hours of dementia training within 30 days of employment. 4. Staff D, a CNA, was hired on 8-26-14 and did not have eight hours of dementia training within 30 days of employment. 5. Staff E, a CNA, was hired on 11-12-14 and did	A 121		

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A 121	Continued From page 3 not have eight hours of dementia training within 30 days of employment. 6. Staff F, a CNA, was hired on 10-17-14 and did not have eight hours of dementia training within 30 days of employment. 7. According to a Program policy and procedure regarding dementia training, all staff or the caregivers of the companies in contract with the Program should be trained in the care of tenants with dementia. All staff or caregivers of the companies in contract with the Program would receive a minimum of eight hours of dementia specific training prior to or within 30 days of employment or at the beginning of the contract. 8. According to the ALP Monitoring Entrance form, the Program had 31 tenants of which 6 tenants were staged at a 4 or greater on the Global Deterioration Scale (GDS). The Program was dementia-specific by definition as there were 5 or more tenants with a GDS of 4 or greater with a total population of fewer than 55 tenants. 8. According to the an interview with the Director on 1-8-15 at 1:20 p.m. the dementia training was not found for Staff A, B, C, D, E and F.	A 121		

Plan of Correction
Iowa City Bickford

A. Record Checks—A118
The Program failed to complete criminal history background checks and abuse history background checks for two of seven staff.

Plan of Correction
The insufficiency will be corrected as follows:
- The Director will ensure that criminal history checks and child and dependent adult abuse checks are completed prior to employment.
- Staff A and Staff B have had all checks completed as of 01/27/2015 with no hits for either employee. Copies of the checks have been printed off and placed in personnel files.

The following measures will be taken to ensure the problem does not recur:
- A new-hire checklist will be followed for completing personnel files to avoid this oversight in the future.

The program will monitor performance to ensure permanent solutions in the following manner:
- Divisional Director of Operations will review personnel files at least twice a year to monitor for compliance.

Date deficiencies corrected by: 01/27/15

B. Dementia Specific Education for Personnel—A121

Regulatory Insufficiency: The Program failed to provide 8 hours dementia-specific training within 30 days of employment for six out of seven staff files.

Plan of Correction:
The insufficiency will be corrected as follows:
- The Director will ensure that 8 hours of dementia-specific training is completed within 30 days of hire. An on-line dementia training program is used, as well as hands-on/face to face training between new hire and RN Coordinator. This hands-on training includes the opportunity for the new-hire to ask RNC for clarification of any and all on-line course content, introducing staff to residents in our program who have dementia and best practices for assisting them, and role play exercises demonstrating possible interactions between staff and a resident with dementia.
- Staff A, B, C, D, E and F completed their on-line and hands-on training by Friday, January 30, 2015.

The following measures will be taken to ensure the problem does not reoccur:
- A new-hire check list will be utilized for completion of personnel files to avoid this oversight in the future.

The Program will monitor performance to ensure compliance as follows:
- Divisional Director of Operations will review personnel files at least twice a year to monitor for compliance.

Date deficiencies corrected by: 1/30/15