IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
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RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #:
53468-I
54463-C

August 25, 2015

Ms. Nancy Stockwell, Director
Bickford Cottage Muscatine
2807 Cedar Street
Muscatine, IA 52761

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

Dear Ms. Stockwell:

I. Final Complaint/Incident Investigation Report – Bickford Cottage Muscatine, Muscatine, 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 **August 12, 13, 17, and 18, 2015.**

The investigation of Incident #53468-I and Complaint #54463-C was completed. There were no regulatory insufficiencies identified related to Incident #53468-I. There were regulatory insufficiencies identified related to Complaint #54463-C and during the course of the investigation. The regulatory insufficiencies are indicated on the enclosed report. The following allegation was investigated in regards to Incident #53468-I:

Allegation: Tenant Rights
Findings: Unsubstantiated
Comments: Based on six tenant file reviews, review of Program documents and staff interviews there were no concerns identified regarding tenant rights. The Report notes Regulatory Insufficiencies in the area(s) of: Service Plans, Nurse Review and Staffing.

Bickford Cottage Muscatine ("Program") is being assessed a **$1,500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a)(b) and 481 IAC 67.17(1)(a)(b).

Pursuant to Iowa Code section 231C.14(1)(a)(b) and 481 IAC rule 67.17(1)(a)(b), 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 and 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.

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.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) 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 **civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm and for repeated Regulatory Insufficiencies in the area of: Service Plans. As the enclosed Report details, the Program also failed to provide access to a 24 hour personal emergency response system to a tenant who fell and fractured a hip.

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 481−67.17(5). 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 **nine hundred seventy five dollars ($975)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

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.

IV. Conclusion

The Program is being assessed a **$1,500 civil penalty** pursuant to Iowa Code section 231C.14(1)(a), (b) and 481 IAC 67.17(1)(a), (b).

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 as provided in IAC rule 481-67.14.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

Jim Friberg

Jim Friberg, Bureau Chief
Adult Services Bureau

Enclosure

cc: Jean Herrity, Legal Assistant
Disability Rights Iowa

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
	S0009	A. BUILDING: _____ B. WING _____	C 08/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE MUSCATINE	2807 CEDAR ST MUSCATINE, IA 52761

(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: 24 Number of tenants with cognitive disorder: 8 Total Population of Program at time of on-site: 32 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 6 Total Population of Program at time of on-site. 6 TOTAL census of Assisted Living Program: 38 An investigation of Incident #53468-I and Complaint #54463-C was completed. There were no regulatory insufficiencies identified related to Incident #53468-I. There were regulatory insufficiencies identified related to Complaint #54463-C and during the course of the investigation.	A 000		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant ' s identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by:	A 089		

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A 089	Continued From page 1 Based on review of tenant files and Program documents the Program failed to develop service plans that reflected the tenants' identified needs and preferences for assistance for three tenants (Tenants #1, #2 and #5). For three tenants the service plans did not reflect the tenants' identified needs and preferences for assistance. (During the course of the investigation) 1. Tenant #1, a 90 year old, was admitted on 11-29-12 and diagnoses included: hyperlipidemia, hypothyroid, chronic obstructive pulmonary disease, osteoarthritis, hypertension (HTN), hemiplegia, hemiparesis and depressive disorder. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. According to a fax to Tenant #1's doctor, Tenant #1 refused to ambulate, even with assist and a prescription for a wheelchair was requested. The order for the wheelchair was noted on 4-23-15. The service plan dated 4-14-15 indicated Tenant #1 ambulated with a cane and assist of one staff. Tenant #1 frequently declined assistance with standing, transfers and ambulation and would request help from other tenants instead of private duty care staff or Program staff. The service plan did not reflect the order for a wheelchair due to Tenant #1's refusal to ambulate The service plan did not reflect the identified needs of Tenant #1. 2. Tenant #2, a 78 year old, was admitted on 7-3-15 and diagnoses included: lewy body dementia, HTN and depression. Tenant #2 was staged at a three on the GDS, which indicated mild cognitive decline. According to a fax, Tenant #2 had been found on	A 089		

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A 089	Continued From page 2 the floor four times since 7-4-15 and was ambulating with a walker. According to a fax, physical therapy (PT) was ordered due to a high risk for falls. The order was noted on 8-5-15. The service plan dated 7-22-15 indicated Tenant #2 ambulated without the use of an assistive device. The service plan did not reflect Tenant #2 ambulated with a walker, had falls and had an order for PT. The service plan did not reflect the identified needs of Tenant #2. 3. Tenant #5, an 87 year old, was admitted on 5-13-14 and had a diagnosis of: cognitive dysfunction. Tenant #5 was staged at a three on the GDS, which indicated mild cognitive decline. According to Progress Notes dated 4-21-15, Tenant #5 was trying to go outside to go home. Tenant #5 threatened to "bust out the window and bust the med aide through the window as well." Progress Notes dated 5-14-15 indicated Tenant #5 was pacing (around) the building and talked about going home and leaving. Tenant #5 slapped another tenant on the calf, according to Progress Notes dated 6-6-15. Progress Notes dated 6-14-15 indicated Tenant #5 was wandering around looking for "families numbers." Tenant #5 kept trying to leave and kept calling "411." According to Progress Notes dated 6-24-15, Tenant #5 pushed the front door open, pushed past staff and hit a staff twice. Tenant #5 told staff to call police, Tenant #5 was leaving. Tenant #5 refused to come back inside the building and punched a staff in the face. Tenant #5 came back inside to take a phone call from Tenant #5's spouse. Progress Notes dated 6-27-15 indicated Tenant #5 was anxious and tried to leave. Tenant #5 spent all day pacing around the building and stopped for meals, according to Progress Notes dated 7-20-15. The service plan dated 6-17-15	A 089		

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A 089	Continued From page 3 did not reflect Tenant #5's behavior and interventions related to the behavior. The service plan did not reflect the identified needs of Tenant #5. 4. According to the Program's policy and procedure regarding service plans, a service plan would be developed and maintained for each tenant that corresponded with their individual needs, preferences and expected outcomes and was based on the tenant's functional and cognitive abilities and health status.	A 089		
A 096	481-69.27(3) Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant ' s condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(3) 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 This REQUIREMENT is not met as evidenced by: Based on review of tenant files and Program documents the Program failed 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 were changes in tenants'	A 096		

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A 096	Continued From page 4 health status for three tenants (Tenants #2, #4 and #5). Nurse reviews were not completed as needed for three tenants when there were changes in the tenants' health status. (During the course of the investigation) 1. Tenant #2, a 78 year old, was admitted on 7-3-15 and diagnoses included: lewy body dementia, hypertension (HTN) and depression. Tenant #2 was staged at a three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline. According to Progress Notes dated 8-6-15, Tenant #2 refused Tenant #2's shower, was very uncooperative, yelled at staff and pinched staff. Progress Notes dated 8-8-15 indicated Tenant #2 was found sleeping on the apartment floor and reported Tenant #2 was more comfortable there. According to Progress Notes dated 8-9-15, Tenant #2 refused to eat breakfast and lunch and refused to drink. Tenant #2 had a large bowel movement, was very tired and confused. A nurse review was not completed regarding Tenant #'2 behavior, refusals to eat or drink and being very tired and confused. A nurse review was not completed as needed. 2. Tenant #4, an 88 year old, was admitted on 11-10-14 and diagnoses included: osteoarthritis, asthma, atrial fibrillation, HTN, chronic renal disease, dementia and anxiety. Tenant #4 was staged at a five on the GDS, which indicated moderately severe cognitive decline. According to Progress Notes dated 8-11-15, staff was showering Tenant #4 and observed three sores on Tenant #4's buttocks Progress Notes dated 8-14-15 indicated Tenant #4 had a runny	A 096		

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A 096	Continued From page 5 nose and a deep cough. A nurse review was not completed related to the documentation of the sores on Tenant #4's buttocks and the runny nose and deep cough. A nurse review was not completed as needed. 3. Tenant #5, an 87 year old, was admitted on 5-13-14 and had a diagnosis of: cognitive dysfunction. Tenant #5 was staged at a three on the GDS, which indicated mild cognitive decline. According to Progress Notes dated 4-21-15, Tenant #5 was trying to go outside to go home. Tenant #5 threatened to "bust out the window and bust the med aide through the window as well." Progress Notes dated 5-14-15 indicated Tenant #5 was pacing (around) the building and talked about going home and leaving. Tenant #5 slapped another tenant on the calf, according to Progress Notes dated 6-6-15. Progress Notes dated 6-14-15 indicated Tenant #5 was wandering around looking for "families numbers." Tenant #5 kept trying to leave and kept calling "411." Nurse reviews were not completed related to Tenant #5's behaviors. Nurse reviews were not completed as needed. 4. According to the Program's policy and procedure regarding nurse review, a nurse review would be completed on every tenant at least every 90 days or after a change in condition. The nurse review would include assessment and documentation of the health status of the tenant, make recommendations and referrals as appropriate and monitor the progress of previous recommendations.	A 096		

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A 115	Continued From page 6	A 115		
A 115	481-69.29(1) Staffing 481-69.29(231C) Staffing. In addition to the general staffing requirements in rule 481-67.9(231B,231C,231D), the following requirements apply to staffing in programs. 69.29(1) Each tenant shall have access to a 24-hour personal emergency response system that automatically identifies the tenant in distress and can be activated with one touch. This REQUIREMENT is not met as evidenced by: Based on review of tenant files, Program documents, observations and staff interviews the Program failed to provide access to a 24-hour emergency response system for a tenant. A pull cord was not working at the time one tenant fell and sustained an injury. When the pull cord was observed at the time of the investigation the pull cord was not working. Although there were two other pull cords available in the apartment, the pull cord located in the bathroom was not working at the time of the fall, was not working when observed at the time of the investigation and there were two entries in the maintenance log regarding repairs of the bathroom pull cord plate (Complaint #54463-C) 1. Tenant #3, an 88 year old, was admitted on 9-22-14 and diagnoses included: atrial fibrillation, chronic obstructive pulmonary disease, hypertension (HTN) and hyperlipidemia. Tenant #3 scored a 24/30 on the Mini Mental Status Exam. 2. Tenant #6, an 86 year old, was admitted on 9-22-14 and diagnoses included: mild cognitive	A 115		

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A 115	Continued From page 7 impairment, HTN, hyperlipidemia and anemia. Tenant #6 was staged at a three on the Global Deterioration Scale, which indicated mild cognitive decline. Tenant #3 and Tenant #6 were spouses and resided in the same apartment. 2. According to an Incident Report, on 7-31-15 at 3:30 p.m., staff answered a call light and Tenant #6 informed staff that Tenant #3 was laying on Tenant #3's back on the floor halfway out of the bathroom. The bathroom door was off the track and was pressing against Tenant #3's temple. Staff got a nurse and the nurse took the door off the track the rest of the way. Tenant #3 had a small skin tear on the right elbow. Water was present around Tenant #3 on the floor. Tenant #3 complained of severe right hip pain and was sent to the hospital Staff reported Tenant #3 said Tenant #3 was going to sit on the toilet and missed at the time of the fall. 3. According to Progress Notes dated 7-31-15, the hospital called and reported Tenant #3 had a femoral right hip fracture. Tenant #3 would have reparative surgery on 8-1-15 or 8-2-15. 4 According to observation on 8-17-15 at approximately 12:30 p.m., Tenant #3's apartment had three pull cords, one in the bathroom and two in the other areas of the apartment (labeled chair and bed on the pull cord history records). The chair and bed pull cords functioned and pull cord history records verified the pull cords had been activated and reset at the time of the observation. The pull cord in Tenant #3's bathroom on 8-17-15 at approximately 12:30 p.m. did not have a cover on the pull cord device or a cord attached to the device at the time of observation. The pull cord in the bathroom did not function at the time of the observation.	A 115		

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A 115	Continued From page 8 5. Pull cord history records for Tenant #3 for July 2015 were reviewed. The bathroom pull cord reflected the cord was activated on 7-24-15. There was no record of any pull cords being activated in Tenant #3's apartment on 7-31-15, when Tenant #3 was found on the floor. 6. According to an interview with Staff A, Tenant #6 was sitting with another tenant outside of the apartment and it was reported Tenant #3 had fallen in the bathroom. Tenant #3 was found laying on the floor with Tenant #3's head in the bedroom and the rest of Tenant #3's body in the bathroom. The door from the bathroom was against Tenant #3's head. There was water on the floor and it was clear liquid with no odor noted. A nurse responded, checked Tenant #3 and asked questions. Staff A said Tenant #3 could not reach the pull cord; however, the pull cord was not working in Tenant #3's bathroom at the time of the fall. Staff A was not alerted to respond to the incident by a pull cord call; however, was doing rounds at the time it was reported. 7 Maintenance logs were reviewed and indicated for Tenant #3's apartment the bathroom pull cord plate was off "again" on 6-11-15 and 6-21-15 and noted it was completed by maintenance staff.	A 115		

Plan of Correction
Muscatine Bickford

A. Service Plans:

Regulatory Insufficiency: The Program failed to develop service plans that reflected the tenants' identified needs and preferences for assistance.

Plan of Correction:
The insufficiency will be corrected as follows:

- RNC will update Service Plans to address the resident's identified needs and preferences, per DIA regulations and Bickford policy.
- Resident #1 moved out prior to this investigation being conducted. Move out date 6/11/15.
- Resident #2 had their Service Plan updated on 8/12/15.
- Resident #5 had their Service Plan updated on 8/19/15.

The following measures will be taken to ensure the problem does not recur:

- The RNC will be re-educated, by Director, on the requirements for service planning to meet the resident's needs and preferences. This will take place on or before September 14, 2015.

The program will monitor performance to ensure permanent solutions in the following manner:

- The Divisional Director of Resident Services will audit Documentation in the charts at least twice a year.
- The Divisional Director of Resident Services will review Service Plans to ensure that they identify the needs and preferences for assistance at least annually.

Date deficiencies corrected by: September 20, 2015

B. Nurse Review:

Regulatory Insufficiency The Program failed 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 were changes in tenants' health status.

Plan of Correction:
The insufficiency will be corrected as follows:

- The RNC will assess and document the health status of each resident and complete a Nurse Review as needed per DIA regulations.

The following measures will be taken to ensure the problem does not reoccur:

- The RNC will be re-educated on the criteria for a Nurse Review as outlined in the regulations, by the Director, on or before September 14, 2015.

The Program will monitor performance to ensure compliance as follows:

- The Divisional Director of Resident Services will audit at least twice a year, the resident charts to determine if Nurse Reviews were completed and appropriate per DIA regulations.

Date deficiencies corrected by: September 14, 2015.

C. **Staffing:**

Regulatory Insufficiency: The Program failed to provide access to a 24 hour emergency response system for a tenant. A pull cord was not working at the time one tenant fell and sustained an injury. When the pull cord was observed at the time of the investigation the pull cord was not working. Although there were two other pull cords available in the apartment, the pull cord located in the bathroom was not working at the time of the fall, was not working when observed at the time of the investigation and there were two entries in the maintenance log regarding repairs of the bathroom pull cord plate.

Plan of Correction:

The insufficiency will be corrected as follows:

- The Maintenance Coordinator will complete maintenance on all pull cords as needed.
- The Maintenance Coordinator fixed the pull cord on August 17, 2015, prior to DIA exiting the Branch.

The following measures will be taken to ensure the problem does not recur:

- The Maintenance Coordinator will be re-educated on or before September 14, 2015 on the importance of fixing pull cords as soon as issues occur, by the Director.

The Program will monitor performance to ensure compliance as follows:

- The Divisional Director of Operations will audit Maintenance logs at least twice a year.

Date deficiencies corrected by: September 14, 2015.