IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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DEMAND LETTER
Complaint Intake #: 58127-I

March 21, 2016

Ms. Samantha Hadden, Director
Bickford Cottage Urbandale
5915 Sutton Place
Urbandale, IA 50322

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

Dear Ms. Hadden:

I. Final Complaint/Incident Investigation Report – Bickford Cottage 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 **March 9 and 15, 2016.** The Report notes Regulatory Insufficiency in the area(s) of: Tenant Rights.

Bickford Cottage Urbandale ("Program") is being assessed a **$8,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

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

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 an **$8,000 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 passed away as the result of inadequate and inappropriate care.

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 **five thousand two hundred dollars ($5,200)** 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 **$8,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

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
	S0042	A. BUILDING: _____ B. WING _____	C 03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE URBANDALE	5915 SUTTON PLACE URBANDALE, IA 50322

(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. General Population Program Number of tenants without cognitive disorder: 44 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 48 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 13 Total Population of Program at time of on-site: 13 TOTAL census of Assisted Living Program: 61 The following regulatory insufficiencies were cited during the investigation of Incident #58127-I	A 000		
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, incident reports, staff file review, and interview a tenant did not receive appropriate services.	A 013		

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A 013	Continued From page 1 1. On 2-18-16, the Program reported Tenant #1 fell, was transported to the hospital and died. Tenant #1 sustained fractures of the cervical spine, the neck, at C1 and C2. The Program reported the staff member involved, Staff A, was not following the service plan and was not using a gait belt for ambulation with Tenant #1. Tenant #1, an 87 year-old, was admitted on 2-2-15 and had diagnoses of: hypertension, Alzheimer's dementia, and Parkinson's disease. On 1-14-16 Tenant #1 was staged at three on the global deterioration scale which indicated mild cognitive decline. Tenant #1 resided in the general population. An incident report dated 11-5-15, documented Tenant #1 turned around and fell, and heard a hip pop. Tenant #1 was sent to the hospital via ambulance. Progress notes dated 12-15-15 documented Tenant #1 returned to the Program on 12-15-15 following repair of a fractured right hip. Progress notes of 12-15-15 also documented Tenant #1 was to receive physical therapy (PT). Evaluations were completed on 12-15-15 and the service plan was updated to include the use of a walker with the assistance of a staff member due to Tenant #1's poor balance. Staff was to use a gait belt with transfers and ambulation. A wheelchair was to be used if Tenant #1 was fatigued. Physical Therapy progress notes dated 1-2-16 documented Tenant #1 was discharged from PT. It was documented Tenant #1 did not show improvement in safe transfers. Tenant #1 had difficulty following up with instructions and retaining new information. Tenant #1 continued to lean to the right. PT recommended to continue	A 013		

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A 013	Continued From page 2 ambulation to and from meals and activities with a gait belt and staff standing on the right side. Evaluations were completed on 1-14-16 and the service plan was updated. Progress notes dated 1-14-16 documented by Staff B, registered nurse (RN), revealed Tenant #1 no longer received therapy services as Tenant #1 did not want to participate. There were no changes to mobility at that time. The service plan dated 1-14-16 continued to include the use of a walker with the assistance of a staff member due to Tenant #1's poor balance. Staff was to use a gait belt with transfers and ambulation. A wheelchair was to be used if Tenant #1 was fatigued. Staff B, RN, was interviewed on 3-15-16 and stated Tenant #1 required the use of the gait belt for safety. Staff was to hold on to the gait belt while Tenant #1 was ambulating. Staff A, Universal Worker (UW), was interviewed on 3-9-16. Staff A reported Tenant #1 was frail, and kept to self. Tenant #1 would talk, but not in context with the conversation. Staff A reported she was on vacation from December 11-31, 2015, and returned approximately 1-1-16. Tenant #1 seemed the same upon Staff A's return to the Program. Staff A stated she did not read the service plan for Tenant #1. Staff A stated she thought a gait belt was to be used with Tenant #1 as needed, not all the time. Staff A stated she used the gait belt with Tenant #1 when getting Tenant #1 out of a low-sitting couch, or when Tenant #1 was uncomfortable moving, or seemed "unstable." Staff A stated she worked on 2-17-16. About 6:00 p.m. Staff A walked with Tenant #1 from the dining room to the apartment. Tenant #1 had a	A 013		

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A 013	Continued From page 3 walker but Staff A stated she did not use a gait belt. When Staff A and Tenant #1 got to Tenant #1's apartment, Staff A held the door open with the left arm while the right arm was on Tenant #1. Staff A was going forward but turned her upper body to catch the door from closing on Tenant #1. When Staff A turned her head back around, Tenant #1 was half way to the floor. Tenant #1 fell to the ground. Staff A reported Tenant #1 had minor skin tears on the right cheek. Tenant #1's eyes were open, and Tenant #1 was grunting, but not responding. Staff A called other staff in to assist. Staff called 911 and Tenant #1 was taken to the hospital. On 3-15-16, Staff A was interviewed and stated she provided care to Tenant #1 about once a week since returning from vacation on 1-1-16, as Staff A worked part-time. Staff A thought she walked with Tenant #1 three to five times between 1-1-16 and 2-17-16. Staff A recalled using the gait belt once because other staff reported Tenant #1 was shaky. Staff A reported the walk with Tenant #1 on 2-17-16 was not the only time she, Staff A, had not used a gait belt. Progress notes dated 2-18-16 completed by Staff B, RN, documented the incident of 2-17-16 and Staff A not using a gait belt for the walking of Tenant #1. Tenant #1 had been transported to the hospital following the fall of 2-17-16 and was found to have a fracture of the C1 and C2 vertebrae. Tenant #1 died in the emergency room according to the progress notes. The certificate of death for Tenant #1 from the Iowa Department of Public Health documented the immediate cause of death was complications of cervical spine fracture due to or as a consequence of a ground level fall.	A 013		

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A 013	Continued From page 4 In summary, Staff A was on vacation when Tenant #1 returned to the Program on 12-15-15 following a fall with fractured hip. The service plan was updated to include the use of a gait belt with ambulation. When the service plan was updated by Staff B, RN, on 1-14-16 following the discontinuation of physical therapy, the use of the gait belt continued to be identified as needed when ambulating Tenant #1. Staff A stated she had not reviewed the service plan since return from vacation and was not aware a gait belt was to be used when ambulating Tenant #1. Staff A reported she had ambulated Tenant #1 on more than one occasion and did not use a gait belt, including the evening of 2-17-16. Tenant #1 fell, sustained cervical spine fractures, and died.	A 013		

Plan of Correction
Urbandale Bickford

A. Tenant Rights

<u>Regulatory Insufficiency:</u> A tenant did not receive appropriate services.

<u>Plan of Correction:</u>
The insufficiency will be corrected as follows:

- The Director has re-educated employees at a Mandatory In-Service on March 15, 2016 on Tenant Rights and the Service Planning Policy.

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

- The Director and RNC will ensure residents are receiving appropriate services through Individualized Care Delivery Core Checks weekly x4 and then monthly for another 6 months. See attached document for further explanation of Individualized Care Delivery Core Check.
- The Director and RNC will communicate in the communication book when service plans are updated for employees to review. Employees initial off on their task sheet once they have reviewed the communication book.

The program will monitor performance to ensure compliance as follows:

- The Divisional Director of Resident Services will perform annual checks on 5% of employees to ensure they are properly reviewing Service Plans, to make them aware of the appropriate services for each resident.

Date deficiencies corrected by: March 22, 2016 and on-going