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 #: 59624-I

May 12, 2016

Ms. Mindy Rowe, 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. Rowe:

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 **April 26 & 27, 2016.** The Report notes Regulatory Insufficiency in the area(s) of: Tenant Rights.

Bickford Cottage Muscatine ("Program") is being assessed a **$1,000 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 a **$1,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, the Program failed to follow the Tenant's service plan and the Tenant eloped from the Program.

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 and remit the civil penalty assessed by check or money order to the **State of Iowa** in the amount of **six hundred and fifty dollars ($650)** 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 **$1,000 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
	S0009	A. BUILDING: _____ B. WING _____	C 04/27/2016

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

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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: 29 Number of tenants with cognitive disorder: 7 Total Population of Program at time of on-site: 36 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: 43 An investigation of Incident #59624-I was completed. There was a regulatory insufficiency identified related to Incident #59624-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 review of a tenant file, staff interviews, observation and review of Program documents the Program failed to provide services that were	A 013		

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A 013	Continued From page 1 adequate and appropriate for one tenant (Tenant #1). Tenant #1's service plan indicated to put the electronic wandering monitoring watch in a sachet bag and pin it to Tenant #1's clothing. It was previously noted Tenant #1 had skin breakdown and was allergic to the band of the watch. Tenant #1 exited the building without staff knowledge and was found at a neighboring business. Tenant #1 was not wearing the electronic wandering monitoring watch at the time of the elopement and the door alarms did not sound when Tenant #1 left the building. The watch was not placed on Tenant #1 the morning of the elopement. Staff did not follow the service plan and provide adequate and appropriate services for Tenant #1. 1. Tenant #1, an 89 year old, was admitted on 1-10-14 and diagnoses included: dementia, hypertension and hyperlipidemia. Tenant #1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. Tenant #1 resided in the general population, which was dementia specific by definition. According to Progress Notes (nurse review) dated 11-23-15, Tenant #1 had an issue with the electronic wandering monitoring watch as Tenant #1 was allergic to the material. The issue was resolved by the placement of the watch in a sachet bag and it being pinned to Tenant #1. According to Tenant #1's service plans dated 11-23-15 and 2-19-16, Tenant #1 had an electronic wandering monitoring watch and was allergic to the band. The watch was in a sachet bag and it needed to be pinned to Tenant #1 by staff. The 2-19-16 service plan was the service plan in effect at the time of the elopement.	A 013		

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A 013	Continued From page 2 According to Progress Notes dated 4-20-16, Tenant #1 was visualized at 3:40 p.m. on the sofa in the living room eating an ice cream sandwich and watching a movie. At 3:57 p.m. a telephone call was received from the Director who stated Tenant #1 was at a business next door. Staff was sent next door to the business to assist Tenant #1 back to the building. Tenant #1 did not have the electronic wandering monitoring watch in place. Upon Tenant #1's return to the Program a head to toe assessment was completed and no injuries were noted. Tenant #1 was assisted to the dedicated dementia unit after returning to the building and then returned to the general population later that evening. An electronic wandering monitoring watch was placed on Tenant #1 and it was tested and alarmed without difficulty. According to Progress Notes dated 4-21-16, an investigation was initiated regarding Tenant #1 being found at the business next door. An incident report was received, no injuries were noted and Tenant #1 stated Tenant #1 was looking for Tenant #1's family. Tenant #1 was last seen at 3:40 p.m. and was escorted back to the building at 3:57 p.m. Staff A provided cares to Tenant #1 that morning and Staff A said Staff A forgot to put the watch on. Tenant #1 had a past reaction to the watch, which caused skin breakdown. Tenant #1's family did not want the watch applied to Tenant #1's skin. Progress Notes dated 4-21-16 indicated Tenant #1 previously had the watch pinned to Tenant #1 in the morning; however, it proved to be unsuccessful. With the permission of Tenant #1's family, the watch was re-applied and staff would perform skin checks three times per day and report any redness.	A 013		

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A 013	Continued From page 3 2. According to an investigation form, an elopement occurred and was reported on 4-20-16. The Director received a phone call from a business and it was reported there was a tenant at the business. Staff C responded and found Tenant #1 in the business next to the Program. Staff C escorted Tenant #1 back to the building. An assessment was completed and no injuries were noted. Tenant #1 was last seen by Staff B at 3:40 p.m. and was reporting in the parking lot at 3:57 p.m. Tenant #1 did not have on the electronic wandering monitoring watch and the service plan indicated to pin a small bag that contained the watch to Tenant #1 as Tenant #1 had a previous reaction to the watch. Staff A, who assisted with morning cares, said Staff A forgot to put on the watch. The plan of action indicated to have the watch applied to Tenant #1's wrist and skin checks would be performed three times daily. The service plan was updated to reflect the changes in the watch status. The watch was not to be removed and if redness appeared the Director or nurse would work together to devise an a plan to keep the watch in place. 3. According to an incident report, the date and time of the occurrence was 4-20-16 at 3:57 p.m. Tenant #1 was visually noted by Staff B in the living room sitting on the sofa eating an ice cream sandwich watching a movie at 3:40 p.m. While Staff B administered medications Staff B received a telephone call from the Director at 3:57 p.m. who stated Tenant #1 was at the business next door. Staff B alerted the nurse and sent staff over to the business to assist with walking Tenant #1 back. Tenant #1 was assisted to the dedicated dementia unit until further safety	A 013		

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A 013	Continued From page 4 measures were completed. Vital signs were taken and were as follows: blood pressure was 126/74, temperature was 97.2, pulse was 80 and respirations were 18. Tenant #1 was taken to the dedicated dementia unit and a call was placed to maintenance staff to have a watch placed. Tenant #1's family and physician were notified. Tenant #1 remained in the dedicated dementia unit per Tenant #1's request for supper and returned to the general population with the watch intact and sounding. 4. According to statement by Staff A, Staff A forgot to put on Tenant #1's watch yesterday morning (4-20-16). According to an interview with Staff A, Staff A helped Tenant #1 with a.m. cares on the day of the elopement. Staff provided verbal cues to Tenant #1 for dressing. Tenant #1 had made no attempts to leave the building previously. Staff B was interviewed and said there was a cruise ship themed activity that day. Staff B was getting things cleaned up and tried to get set up for supper. Tenant #1 was in living room sitting on the couch. Tenant #2 asked for Tylenol and it was administered at approximately 3:30/3:40 p.m. When Staff B brought the Tylenol to Tenant #2, Staff B made eye contact with Tenant #1. Staff B went into the medication room to go over orders and started the medication pass. About 20 minutes later Staff B received a telephone call from the Director. The Director said Tenant #1 was at the business next door and Staff B sent Staff C to the business to get Tenant #1. A head to toe assessment was completed and Tenant #1 did not have any injuries. Tenant #1 was dressed in a suit and was wearing shoes. Tenant #1 ambulated independently, without an assistive device and had a steady gait. Staff B said there	A 013		

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A 013	Continued From page 5 were no pagers or door alarms (related to Tenant #1 exiting the building). Maintenance staff was contacted so a watch could be applied. Staff B was informed Tenant #1's family had previously refused the placement of the watch due to a skin allergy. Tenant #1 had not worn a watch since that time. Staff B did not recall seeing Tenant #1 wear the watch on Tenant #1's person or on Tenant #1's wrist prior to the incident. After the incident, Tenant #1 had been wearing a electronic wandering monitoring watch and there had been no irritation to Tenant #1's skin. Tenant #1 did not have a history of elopement. Staff B indicated in interview Staff B administered Tylenol to Tenant #2 and visualized Tenant #1 at that time. Tenant #2's medication administration records indicated Tylenol was administered by Staff B at 3:45 p.m. on 4-20-16. Staff C was interviewed and said Staff C was told Tenant #1 was at the business next door. Staff C went to the business next door and Tenant #1 was sitting in the lobby. Tenant #1 said Tenant #1 called a ride and that person opened the door and Tenant #1 got out. Tenant #1 was agreeable to return to the Program. Tenant #1 was not wearing the electronic wandering monitoring watch. Prior to Tenant #1 leaving that day the alarm did not go off. Tenant #1 had not eloped prior to the incident. According to a statement by Staff D, upon doing cares for Tenant #1 Staff D did pin a watch on Tenant #1's garments as asked by Tenant #1's family. The watch caused skin rashes on Tenant #1's wrist. Staff D had not seen the watch since the small bag that held it broke. According to a statement by Staff E, Staff E found	A 013		

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A 013	Continued From page 6 a watch sitting on Tenant #1's dresser drawer. Staff E took the watch and put in the box for the Former Nurse. The Former Nurse was notified regarding finding the watch in Tenant #1's apartment. Staff E was not sure of the exact timeframe, it was right before the Former Nurse left. Per a Program document, the Former Nurse was no longer employed with an effective date of 4-6-16. According to a statement by Staff F, Staff F had completed a.m. cares for Tenant #1 in the past and had assisted Tenant #1 with dressing. Staff F had put the watch and the bag into Tenant #1's pocket and clipped it to Tenant #1's pants. Staff F had not been working in the building since 4-6-16 and had not used the watch since. Staff G was interviewed and indicated Staff G helped Tenant #1 with a shower and a.m. cares every Thursday. When Staff G worked Staff G pinned the bag with watch to Tenant #1's clothing. The Director was interviewed and said she received a telephone from the business next door and was told Tenant #1 was at the business. Tenant #1 had reported Tenant #1 had been dropped off and was looking for a family member's phone number. The Director called the building and spoke with Staff B and Staff B sent Staff C to get Tenant #1. During the investigation it was determined Staff A had not put the electronic wandering monitoring watch on Tenant #1 that morning. The estimated time Tenant #1 was gone was approximately 15 minutes and there was no prior history of elopement with Tenant #1. A new watch was put on Tenant #1 after the elopement. The Director said no staff	A 013		

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A 013	Continued From page 7 had brought to her attention any issues with the watch or bag for Tenant #1. RN #1 was interviewed and said she was notified by Staff B about the incident with Tenant #1. An investigation was started. The incident was not witnessed and the estimated time Tenant #1 was gone was 15 to 18 minutes. At the time of the elopement Tenant #1 was not wearing the electronic wandering monitoring watch and the door alarms did not go off. Tenant #1 was dressed appropriately for the weather. RN #1 talked to Staff A who said she had read the service plan and knew but forgot (regarding the placement of the watch) but also did not know where the watch was. RN #1 said Staff D said she did initially pin the watch on Tenant #1; however, at some time the sachet bag broke and she had not seen the watch. RN #1 said Staff E reported the sachet bag broke and the watch was taken to the Former Nurse. RN #1 said no staff had brought to her attention any issues with the watch or bag for Tenant #1. RN #2 was interviewed and said Staff B received a telephone call and was told Tenant #1 was at the business next door. Staff C brought Tenant #1 back to the building. Tenant #1 was not wearing an electronic wandering monitoring watch when Tenant #1 returned to building and the door alarms did not go off when Tenant #1 left the building. Tenant #1 had no injuries and was taken to the dedicated dementia unit and ate supper. Maintenance staff programmed a watch for Tenant #1. 5. According to a Program document, Staff A receiving a counseling form related to the incident with Tenant #1. The form indicated the service plan was not followed when cares were provided.	A 013		

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A 013	Continued From page 8 Tenant #1 did not have the electronic wandering monitoring watch pinned to Tenant #1. Tenant #1 was to have the watch pinned to Tenant #1 with the a.m. cares every morning. Tenant #1 eloped as a result of the service plan not being followed appropriately. The follow up indicated Staff A would read and follow all aspects of the service plan when providing cares to tenants. If there were cares that were on the service plan, but appropriate tools were not available, Staff A would notify the nurse on call for further instruction. 6. Tenant #1's elopement was not witnessed and it could not be determined which route Tenant #1 took to leave the building and arrive at the business next door. Possible terrain included: sidewalks, grass and concrete parking lots. The Program was located off of a two lane city street with a posted speed limit of 35 miles per hour (mph) (a sign indicated the speed limit was 25 mph when flashing due a school zone). There was a sidewalk parallel to the city street. When traveled by car, the distance from the driveway of the business next door to the driveway of the Program was less than 0.1 of a mile. Driving directions from a website indicated the distance between the Program and the business next door was 0.1 of a mile. 7. The records for Tenant #1's electronic wandering monitoring watch were obtained. From 9-30-15 at 12:27 p.m. to 4-20-16 at 5:40 p.m. there were no alarms reflected. There were alarms reflected prior to 9-30-15 and after 4-20-16 for Tenant #1; however, none during that time period. 8. According to the State Climatologist, conditions at the local airport on 4-20-16 at 3:55 p.m. were as follows: temperature was 63	A 013		

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A 013	Continued From page 9 degrees, winds were from the south at 10 mph and there were cloudy skies. It had rained at 1:55 p.m.; however, there was no precipitation at that time.	A 013		

Plan of Correction
Muscatine Bickford

A 013 Tenant Rights

Regulatory Insufficiency: The Program failed to provide services that were adequate and appropriate for one tenant.

Plan of Correction:

The insufficiency will be corrected as follows:

- The Director and RNC re-educated all staff at a Mandatory In-Service on April 28, 2016 on Tenant Rights and the Service Planning Policy.
- The RNC updated Tenant #1 Service Plan to reflect current services on April 21, 2016.

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

- The Director and RNC will communicate via communication book when Service Plans are updated for staff to review.
- Maintenance will monitor home free monthly to ensure proper functioning of all home free equipment.

The program will monitor performance to ensure compliance as follows:

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

Date deficiencies corrected by: April 28, 2016 and on-going