

OK
11/21/20

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/08/2019
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NAME OF PROVIDER OR SUPPLIER BICKFORD COTTAGE URBANDALE	STREET ADDRESS, CITY, STATE, ZIP CODE 5915 SUTTON PLACE URBANDALE, IA 50322
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✓ 11/23/20

(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
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A 000	<p>Initial Comments</p> <p>Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site.</p> <p>General Population Number of tenants without cognitive disorder: 31 Number of tenants with cognitive disorder: 8</p> <p>Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 12</p> <p>TOTAL Census of Assisted Living Program for People with Dementia: 51</p> <p>The following regulatory insufficiencies were cited during the Investigation of Complaint #86202-C and Incident #86210-I.</p>	A 000	<p>See attached</p> <p>POC 11/21/19</p>	
A 013	<p>481-67.3(2) Tenant Rights</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review the Program failed to provide care, treatment and adequate/appropriate services as directed by service plans. This affected 1 of 4 tenants (Tenant #1) reviewed as a result of investigations #86210-I and #86202-C. Findings follow:</p>	A 013		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A 013	<p>Continued From page 1</p> <p>Tenant #1 resided in a dedicated dementia assisted living program and was a four (4) on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #1's Service Plan, dated 6-5-19, indicated he had disabled the security system at his last assisted living facility. He required temporary 10 minute checks due to recent elopement and staff interventions of activities for exit seeking behavior and agitation. The tenant's service plan also indicated a high risk of elopement and safety alarms to be installed on all windows in the dementia unit as a result.</p> <p>Record review revealed a facility incident report dated 9-1-19 at 11:45 a.m. documented, "CMA (certified medication aide) noticed resident not in main area around 11:45 a.m. and started looking for him and noticed the kitchen window wide open. All staff were notified to search in all areas. Tenant returned with no pain or discomfort and vitals were WNL (within normal limits).</p> <p>According to the state climatologist the nearest weather report available was from the Des Moines International Airport at 11:45 a.m. At that time the temperature was 76 degrees, skies were cloudy with 10 mile visibility and the wind was from the southwest at 7 mph. The humidity was 65% with no heat index computed for that time.</p> <p>Observations revealed the Program was located on Sutton Place in a 25 mile per hour speed zone with two lanes of traffic and approximately one half mile south of Interstate 80/35. The tenant opened a window in the kitchenette area and removed the screen to exit the building. He most likely walked around the building to the public sidewalk and continued west approximately .2</p>	A 013		

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A 013	<p>Continued From page 2</p> <p>miles in a residential neighborhood and wooded area.</p> <p>Staff A stated on 10-2-19 at 11:06 a.m. she observed Tenant #1 in the dining room around 11:45 a.m. She stated a tenant approached her and required medical attention for a cut and Staff H was toileting another tenant. Staff A stated she attended to the wound and after a few minutes noticed Tenant #1's absence from the dining area. She stated she completed a room to room search and called for assistance. She stated another staff called on the walkie to say Tenant #1 had been found and then as she walked by the kitchen, she noticed the open window and screen removed from it. She confirmed the window did not have an alarm installed on it but the windows in the tenants' apartments had window alarms. Staff A stated she called the on call RN (Registered Nurse) and was instructed to notify maintenance of the incident. She stated he did not show up before the end of her shift at 2:00 p.m., so she locked the kitchen door.</p> <p>Staff H stated on 10-2-19 at 2:00 p.m. she took a tenant to her room and Staff A communicated via walkie that Tenant #1 was missing. She stated she noticed the kitchen window was open, screen had been removed, and no alarm was installed on this window. She stated he was found approximately 15 minutes later with no apparent injuries. She stated she communicated to the oncoming staff he required 10-15 minutes checks due to elopement and to redirect with activities as needed.</p> <p>Staff B stated on 10-7-19 at 10:23 a.m. she worked in the assisted living area of the Program on 9-1-19. She stated the front doorbell rang and a neighbor was at the door asking if the Program</p>	A 013		

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A 013	<p>Continued From page 3</p> <p>was missing someone. She asked him what the person looked like and he described Tenant #1. She stated she left with the man to where Tenant #1 was located. She stated he stood on the sidewalk and said he was "looking for the train." Staff B told him his wife was on her way to pick him up for lunch and he proceeded to walk with her back to the Program. She stated it was a nice day, was dressed appropriately for the weather, and had no apparent injuries.</p> <p>When interviewed on 10-2-19 at 3:16 p.m. Staff C reported after Tenant #1 eloped in June 2019, the Program decided to alarm the windows in the memory care unit. He installed window alarms on all windows in the memory care unit apartments and stated it did not occur to him to alarm the window in the kitchen area since it was visible to staff.</p> <p>The RN (Registered Nurse) Coordinator stated on 10-7-19 at 12:47 p.m. Staff C received a written counseling for failing to alarm all windows in the memory care unit as documented in Tenant #1's service plan.</p> <p>2. Continued review revealed a facility incident report dated 9-1-19 at 6:45 p.m. documented, "CMA checked residents apartment and noticed he was not there and called for help when he could not be found. Resident was found in parking lot and stated he was looking for his wife. No apparent injuries noted and one to one supervision was implemented."</p> <p>According to the state climatologist the nearest weather report available was from the Des Moines International Airport at 6:45 p.m. At that time the temperature was 73 degrees, skies were</p>	A 013		

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A 013	<p>Continued From page 4</p> <p>cloudy with 10 mile visibility and the wind was from the south at 3 mph. The humidity was 73% with no heat index computed for that time.</p> <p>Observations revealed the Program was located on Sutton Place in a 25 mile per hour speed zone with two lanes of traffic and approximately one half mile south of Interstate 80/35. Tenant #1 most likely exited through the courtyard doors, dismantled the security system for the lock, and exited the gated area. The tenant was found in the parking lot approximately 50 feet from the courtyard.</p> <p>Staff E stated on 10-3-19 at 1:37 p.m. she observed Tenant #1 in the immediate area around the medication room in the memory care unit. She stated she noticed another tenant go into an apartment and told Tenant #1 she would be right back and left him unsupervised as the other staff was doing the dishes. She stated the other tenant made a mess in the apartment and stayed to clean it up. When she returned she could not find Tenant #1. She stated she called for assistance and looked for him inside and outside the building. She stated Staff D came over from the assisted living and noticed him outside the courtyard in the parking lot. She stated she went outside and noticed the gate was opened and the keypad box was disassembled. She stated she noticed Tenant #1's hands were dirty and assumed he had disassembled the box himself to open the gate. Staff E stated she completed 15 minute checks during the shift and the documentation could not be located. She stated 2 staff worked the memory care unit and it was typical for one staff to leave to do the dishes in the evening.</p> <p>When interviewed on 10-2-19 at 2:42 p.m. Staff F</p>	A 013		
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A 013	<p>Continued From page 5</p> <p>stated she worked the memory care unit and the previous shift informed her Tenant #1 eloped earlier that day and required enhanced checks. She could not recall how often they were to be done or if they were to be documented. She stated she observed Tenant #1 in the dining area after supper and left to do the dishes in the main kitchen. She stated Staff E remained in the memory care unit and later she called on the walkie that Tenant #1 was gone. She stated she looked in the apartments and he was not there. She stated she went into the courtyard and observed Staff D standing next to him in the parking lot. She stated the gate was open and the code box was broken with exposed wires. She stated Tenant #1's hands had black dirt on them and assumed he took the box apart.</p> <p>When interviewed on 10-2-19 at 10:52 a.m. Staff D stated Tenant #1 returned from a visit with family approximately 6:30 p.m. She stated she worked the assisted living area and Staff E called for assistance to locate Tenant #1. She stated she they looked room to room then went outside and she observed him in the parking lot. She noticed the box to enter the code to open the gate was open with exposed wires. She stated she went to Tenant #1 and he willingly returned to the Program. She noted dirt on his hands and appeared he had dismantled the box and messed with the wires.</p> <p>When interviewed on 10-2-19 at 10:41 a.m. the Assistant Director stated the memory care unit required two staff present at all times. Staff were to call the assisted living staff for assistance if they needed to leave the unit. She stated Staff E and Staff F received written counseling for not providing appropriate supervision to tenants in the memory care unit. She confirmed Tenant #1 had</p>	A 013		

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A 013	Continued From page 6 one previous elopement prior to 9-1-19 and eloped from an assisted living prior to moving here. She stated his service plan included interventions of alarmed windows and redirection from staff when needed. The RN Coordinator confirmed on 10-7-19 at 12:47 p.m. the memory care unit required two staff present at all times. She stated one staff should be present in the common area while other staff passed meds or completed cares. She stated this was the expectation communicated to staff during the initial training.	A 013		
A 055	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide a sufficient number of staff to meet the needs of the tenants in a dementia unit. This affected 1 of 4 tenants (Tenant #1) reviewed as a result of investigations #86210-I and #86202-C and potentially affected 12 of 12 tenants. Findings follow: Tenant #1 resided in a dedicated dementia assisted living program and had a Global Deterioration Scale of 4, which indicated moderate cognitive decline. Tenant #1's Service Plan, dated 6-5-19, indicated he disabled the	A 055		

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A 055	<p>Continued From page 7</p> <p>security system at his last assisted living facility. He required temporary 10 minute checks due to recent elopement and staff interventions of activities for exit seeking behavior and agitation. The tenant's service plan also indicated a high risk of elopement and safety alarms to be installed on all windows in the dementia unit.</p> <p>Record review revealed a facility incident report dated 9-1-19 at 11:45 a.m. documented, "CMA (certified medication aide) noticed resident not in main area around 11:45 a.m. and started looking for him and noticed the kitchen window wide open. All staff were notified to search in all areas. Tenant returned with no pain or discomfort and vitals were WNL (within normal limits).</p> <p>Staff A stated on 10-2-19 at 11:06 a.m. she observed Tenant #1 in the dining room around 11:45 a.m.. She stated a tenant approached her and required medical attention for a cut and Staff H was toileting another tenant. Staff A stated she attended to the wound and after a few minutes noticed Tenant #1's absence from the dining area. She stated she completed a room to room search and called for assistance. She stated another staff called on the walkie to say Tenant #1 had been found and then as she walked by the kitchen, she noticed the open window and screen removed from it. She confirmed the window did not have an alarm installed on it but the windows in the tenants apartments have window alarms. Staff A stated she called the on call RN (Registered Nurse) and was instructed to notify maintenance of the incident. She stated he did not show up before the end of her shift at 2 p.m. so she locked the kitchen door.</p> <p>Staff H stated on 10-2-19 at 2:00 p.m. she took a tenant to her room and Staff A communicated via</p>	A 055		

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A 055	<p>Continued From page 8</p> <p>walkie that Tenant #1 was missing. She stated she noticed the kitchen window was open, screen had been removed, and no alarm was installed on this window. She stated he was found approximately 15 minutes later with no apparent injuries. She stated she communicated to the oncoming staff he required 10-15 minutes checks due to elopement and to redirect with activities as needed.</p> <p>Continued review revealed a facility incident report dated 9-1-19 at 6:45 p.m. documented, "CMA checked residents apartment and noticed he was not there and called for help when he could not be found. Resident was found in parking lot and stated he was looking for his wife. No apparent injuries noted and one to one supervision was implemented."</p> <p>Staff E stated on 10-3-19 at 1:37 p.m. she observed Tenant #1 in the immediate area around the medication room in the memory care unit. She stated she noticed another tenant go into an apartment and told Tenant #1 she would be right back and left him unsupervised as the other staff was doing the dishes. She stated the other tenant made a mess in the apartment and stayed to clean it up and when she returned she could not find Tenant #1. She stated she called for assistance and looked for him inside and outside the building. She stated Staff D came over from the assisted living and noticed him outside the courtyard in the parking lot. She stated she went outside and noticed the gate was opened and the keypad box was disassembled. She stated she noticed Tenant #1's hands were dirty and assumed he had disassembled the box himself to open the gate. Staff E stated she completed 15 minute checks during the shift and the documentation could not be located. She stated 2</p>	A 055		

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A 055	<p>Continued From page 9</p> <p>staff worked the memory care unit and it was typical for one staff to leave to do the dishes in the evening.</p> <p>Staff F stated on 10-2-19 at 2:42 p.m. she worked the memory care unit and the previous shift informed her Tenant #1 eloped earlier that day and required enhanced checks and did not remember how often they were to be done or if they were to be documented. She stated she observed Tenant #1 in the dining area after supper and left to do the dishes in the main kitchen. She stated Staff E remained in the memory care unit and later she called on the walkie that Tenant #1 was gone. She stated she looked in the apartments and he was not there. She stated she went into the courtyard and observed Staff D standing next to him in the parking lot. She stated the gate was open and the code box was broken with exposed wires. She stated Tenant #1's hands had black dirt on them and assumed he took the box apart.</p> <p>Staff D stated on 10-2-19 at 10:52 a.m. Tenant #1 returned from a visit with family approximately 6:30 p.m. She stated she worked the assisted living area and Staff E called for assistance to locate Tenant #1. She stated she they looked room to room then went outside and she observed him in the parking lot. She noticed the box to enter the code to open the gate was open with exposed wires. She stated she went to Tenant #1 and he willingly returned to the Program. She noted dirt on his hands and appeared he had dismantled the box and messed with the wires.</p> <p>The Assistant Director stated on 10-2-19 at 10:41 a.m. the memory care unit required 2 staff present at all times. Staff were to call the assisted</p>	A 055		

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A 055	<p>Continued From page 10</p> <p>living staff for assistance if they needed to leave the unit. She stated Staff E and Staff F received written counseling for not providing appropriate supervision to tenants in the memory care unit. She confirmed Tenant #1 had one previous elopement prior to 9-1-19 and eloped from an assisted living prior to moving here. She stated his service plan included interventions of alarmed windows and redirection from staff when needed.</p> <p>The RN Coordinator confirmed on 10-7-19 at 12:47 p.m. the memory care unit required 2 staff present at all times. She stated one staff should be present in the common area while other staff passed meds or completed cares. She stated this was the expectation communicated to staff during the initial training.</p>	A 055		
A 056	<p>481-67.9(2) Staffing</p> <p>481-67.9(231B,231C,231D) Staffing. 67.9(2) Emergency procedures. All program staff shall be able to implement the accident, fire safety, and emergency procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to implement fire safety procedures. This potentially affected 12 of 12 tenants in the dementia unit. Findings follow:</p> <p>Staff G stated on 10-2-19 at 11:04 p.m. she had observed at times a rocking chair or a large chest blocking a fire door in the dementia unit. She stated she moved the items and would tell the assigned staff not to block the exit. She stated no</p>	A 056		

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A 056	<p>Continued From page 11</p> <p>one would take responsibility for putting the items in front of the door and did not know if it was there from the previous shift. She confirmed tenants had a history of exit seeking behaviors and elopements and currently resided in the memory care unit.</p> <p>Staff E stated on 10-3-19 at 1:37 p.m. she observed furniture placed in front of the fire door in the memory care unit on occasion. She stated she cleared the door when this occurred and stated no one would admit to putting it there. She stated she had done this one time last year when she needed to pass medications.</p> <p>The Assistant Director confirmed a family member had sent a picture on 9-28-19 to Branch Support that revealed a chest and a pillow blocking a fire exit in the dementia unit. She stated she received the picture by text the following day from the Regional Director. She called the Program and instructed a staff to put a "Do not block door" sign on the exit door. She stated she interviewed staff and no one would take responsibility for blocking the door. She stated all staff were re-educated and no issues were noted after this incident. She confirmed the dementia unit had tenants that exhibited exit seeking behaviors and had a history of elopement.</p>	A 056		

Plan of Correction
Urbandale Bickford Cottage

OK
1/29/2020
2/3/20

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.

Regulatory Insufficiency: Program failed to provide care, treatment and adequate/appropriate services as directed by service plans.

Plan of Correction:

The insufficiency will be corrected as follows:

- Maintenance Director installed an alarm to the memory unit kitchen window on 11/04/2019. All memory care unit windows are now alarmed. Assistant Director and RNC conducted an all-staff mandatory in-service on 9/11/19, reviewing the policy regarding Missing Resident Drills, Unwitnessed Door alarm Drills and following Task Sheets to ensure that there is never only 1 person in the Memory Unit.

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

- Alarms are check every Friday by Maintenance Director to ensure they are functioning properly.
- Tasks sheets are reviewed daily by Assistant Director
- Missing Resident Policy reviewed upon initial employment and quarterly during Missing Resident and Unwitnessed Door alarm drills.

The Program will monitor performance to ensure compliance as follows:

- Divisionals will audit program to ensure safety compliance

A 055 481-67.9(1) Staffing

481-67.9(231B,231C,231D) Staffing.
67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

Regulatory Insufficiency: Program failed to provide a sufficient number of staff to meet the needs of the tenants in a dementia unit.

Plan of Correction:

The insufficiency will be corrected as follows:

- Task Sheets were reviewed and updated to ensure 2 BFM's members are present in Memory Unit at all times.
- In-Service held on 9/11/2019 reviewed updated task sheet.

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

- Tasks sheets are reviewed daily by Assistant Director.
- Directors conduct random audits after business hours to ensure 2 BFM's in Memory Unit.

The Program will monitor performance to ensure compliance as follows:

- Random audits discussed during bi-monthly core calls.

A 056 481-67.9(2) Staffing

481-67.9(231B,231C,231D) Staffing.

67.9(2) Emergency procedures. All program staff shall be able to implement the accident, fire safety, and emergency procedures.

Regulatory Insufficiency: Program failed to implement fire safety procedures. This potentially affected 12 of 12 tenants in the dementia unit.

Plan of Correction:

The insufficiency will be corrected as follows:

- The Assistant Director reviewed Emergency Handbook during an all-staff mandatory in-service on 9/11/2019, including fire safety.
- During 9/11/2019 all-staff mandatory in-service not blocking exit doors reviewed.
- Exits doors are checked daily to ensure they are not blocked.

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

- Daily audits of all Fire Doors conducted and logged

The Program will monitor performance to ensure compliance as follows:

- Divisionals will conduct random audits of program to ensure safety compliance

Date deficiencies corrected by: 11/21/2019