

✓ 11/7/17 OK
11/17/17

PRINTED: 10/25/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IAALP023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/05/2017
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NAME OF PROVIDER OR SUPPLIER BICKFORD COTTAGE IOWA CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 LOWER W BRANCH RD IOWA CITY, IA 52245
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(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>481-67 Initial Comments</p> <p>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.</p> <p>Dementia-Specific Program by Definition</p> <p>Number of tenants without cognitive disorder: 27 Number of tenants with cognitive disorder: 7 Total Population of Program at time of on-site: 34</p> <p>TOTAL census of Assisted Living Program: 34</p> <p>The investigation of #69217-J resulted in the following regulatory insufficiencies cited:</p>	A 000	<p>See attached</p> <p>POC 11/8/17</p>	
A 089	<p>481-69.26(4)a Service Plans</p> <p>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</p> <p>This Requirement is not met as evidenced by: Based on interview and record review the Program failed to develop service plans to reflect the identified needs of tenants. This affected 1 of 2 tenants reviewed (Tenants #1). Findings follow:</p> <p>1. Record review revealed Tenant #1's diagnoses included: dementia and alcohol abuse. Tenant #1 was admitted on 6-5-17 and was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline.</p> <p>According to an Investigation Form, Tenant #1</p>	A 089		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 089	<p>Continued From Page 1</p> <p>eloped on 6-27-17. According to a statement from the Nurse dated 6-27-17, she was notified by staff on 6-27-17 at 1:45 p.m. that Tenant #1 was absent from the building. Staff received a telephone call from a police officer to report Tenant #1 was taken to his/her home. The Nurse arrived to Tenant #1's home and spoke with the officer who stated Tenant #1 was found at a location a half mile from the building. Tenant #1 had no injuries and was returned to the Program.</p> <p>See 69.32(2) for additional information regarding the incident.</p> <p>The ALP Monitoring Entrance Form reflected Tenant #1 wandered.</p> <p>Review of Tenant #1's service plan revealed the last update occurred 6-28-17, as a 30 day review. The service plan failed to reflect Tenant #1's elopement the day prior. Additionally, the service plan failed to reflect Tenant #1's wandering behavior and interventions related to the behavior.</p> <p>Interviews with the Nurse on 10-5-17 at 11:25 a.m. and 10-9-17 at approximately 9:30 a.m. reflected Tenant #1's would wander through the building (common areas) asking for beers, and then go to his/her apartment. Tenant #1 did not exit seek and spoke of wanting to see his/her spouse and wanting to call family.</p> <p>2. Record review revealed Tenant #1's Progress Notes indicated the following:</p> <p>a. On 6-30-17, the tenant fell backwards.</p> <p>b. On 7-5-17 Tenant #1 fell backwards at lunch and hit his/her head. Tenant #1 was also found later on the floor in his/her apartment.</p>	A 089		

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A 089	Continued From Page 2 c. On 7-28-17 Tenant #1 had two small skin tears on his/her face with an unknown etiology. d. On 7-31-17 Tenant #1 complained of pain in the lower back; however, ambulated without difficulty. e. On 8-1-17 family took Tenant #1 out for complaints of pain and new orders were received. f. On 8-7-17 Tenant #1 stumbled and fell to the floor. Tenant #1 hit his/her right hip and elbow and was sent to urgent care via family. g. On 8-8-17 Tenant #1 was treated at urgent care, sutures were in place and the dressing to the right elbow was intact. h. On 8-23-17 Tenant #1 fell backwards and hit his/her head. Additional record review revealed a 90 day nurse review, dated 8-31-17, indicated Tenant #1 had four falls in the past 90 days. Continued record review revealed Tenant #1's service plan did not reflect Tenant #1's falls or interventions related to the falls. The service plan failed to reflect the identified needs of Tenant #1.	A 089		
A 138	481-69.32(2) Life Safety 481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements. 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.	A 138		

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A 138	<p>Continued From Page 3</p> <p>This Requirement is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure an operational door alarm system as required for a dementia-specific program. This affected 1 of 2 tenants reviewed (Tenant #1). Findings follow:</p> <p>1. Record review revealed Tenant #1's diagnoses included: dementia and alcohol abuse. Tenant #1 was admitted on 6-5-17 and staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline, upon assessment. Tenant #1 wore a electronic wander device.</p> <p>The Program was dementia-specific and had alarmed exterior doors. The exterior doors included a delayed egress function, as well as an electronic wandering monitoring system present on the exterior doors. According to Resident Monitoring System Watch, Panic Button and Fall Detection Device policy, a tenant would use an electronic wander device if certain triggers were met. Noted triggers included: mentation score of three or more; social score of five or more; safety score of two; inappropriate behavior at mealtimes, interrupting others' mealtime, and</p> <p>Record review revealed an investigation form, dated 6/27/17, documented Tenant #1 found outside of the Program by an Iowa City police officer. The officer identified the tenant as a resident of Bickford Cottage based on his/her Wanderguard transmitter. The investigation concluded the monitoring system failed to register Tenant #1 leaving the building. A plan of action indicated Tenant #1 was assigned a new Wanderguard transmitter, which had been test to confirm it was functional.</p>	A 138			

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A 138	Continued From Page 4 Further review revealed a statement from the Nurse, dated 6/27/17. The Nurse reported she received a phone call from Staff A at 1:45 p.m. on 6/27/17 notifying her Tenant #1 was absent from the Program. Staff A informed the Nurse she received a phone call from an Iowa City police officer. The officer took Tenant #1 to his home. The Nurse drove to Tenant #1's home, arriving around 1:50 p.m. Upon arrival, Tenant #1 stood on the front porch, alert and talking with his/her Wanderguard wrist band monitor intact. The officer reported Tenant #1 had been found on the corner of Scott and Court. The Nurse noted this as an 11 minute walk and half a mile from the Program, according to Google maps. She noted Tenant #1 wore jeans, socks, shoes, and a short sleeved shirt. Upon arrival to the Program at 2:00 p.m., Tenant #1's transmitter did not register him/her as returning. The Nurse completed an assessment and noted no injuries. The Nurse and former Director confirmed Tenant #1's write monitor failed; the monitoring system showed no indication Tenant #1 left the building and no pagers alarmed. All internal and external doors were checked and found to working appropriately. They concluded Tenant #1's Wanderguard wrist monitor failed. The monitor was replaced at 2:45, and checked to ensure it worked appropriately. According to the Nurse's statement dated 6-27-17, Tenant #1 was found at the corner of Scott Boulevard and Court Street. The distance was driven in a car and was approximately 0.5 mile from the parking lot of the Program to the location provided in the Nurse's statement. The elopement was not witnessed; however, possible terrain Tenant #1 covered included: sidewalk, grass and city streets. Scott Boulevard was a two lane city street with a posted speed limit of 35 miles per hour (mph). There were sidewalks	A 138		

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A 138	<p>Continued From Page 5</p> <p>observed on each the street. In the area Tenant #1 was located, Court Street was a two lane city street with a posted speed limit of 25 mph.</p> <p>The State Climatologist provided the following information: at the Iowa City Airport on 6-27-17 at 12:52 p.m. the temperature was 74 degrees, winds were light and variable, there were clear skies and humidity was 38%. On 6-27-17 at 1:52 p.m. the temperature was 75 degrees, winds were from the southeast at 12 mph, there were clear skies and humidity was 34%.</p> <p>Record review revealed Tenant #1's service plan, dated 5/31/17, noted he/she ambulated independently. Tenant #1 had a walker, but elected to not use it consistently. The service plan noted staff would provide Tenant #1 with escorts to and from meals and activities he/she chose to participate in. The service plan also documented Tenant #1 moved to Bickford Cottage from his/her home after being found wandering to a neighbor's house multiple times complaining of being cold. The tenant recently incurred a mechanical fall with compression fractures of the spine. Tenant #1 moved to Bickford Cottage due to increasing confusion, alcohol intake, and requiring more assistance with activities of daily living.</p> <p>When interviewed on 10-5-17 at 11:25 a.m. the Nurse revealed police located Tenant #1 outside and picked him/her up. The officer noticed Tenant #1's Wanderguard transmitter and identified the tenant as a resident of Bickford Cottage. The tenant gave the officer his/her home address and the police took him/her there. The Nurse went to Tenant #1's house and found Tenant #1 on the front porch with the officer. Tenant #1 returned to the Program with the Nurse without issue. When Tenant #1 returned to the building, no alarm sounded, nor was there any record of Tenant #1</p>	A 138		

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A 138	<p>Continued From Page 6</p> <p>leaving. It was determined his/her Wanderguard wrist monitor did not work, and the device was replaced. An assessment was completed when Tenant #1 returned to the Program, and no concerns were noted. The Nurse reported it was a nice day and Tenant #1 dressed appropriately for the weather. According to the nurse, Tenant #1 ambulated independently and required no assistive devices. The Nurse reported staff saw Tenant #1 at lunch, served around noon, and also after lunch about 30-40 minutes later. Tenant #1 frequently wandered throughout the common areas and his/her apartment, but had no exit seeking behavior. The Nurse confirmed the door alarms failed, resulting in Tenant #1's elopement. According to the Nurse the delayed egress failed and did not alarm, nor did the Wanderguard system.</p> <p>Staff A was unavailable for interview; however, record review revealed Staff A's statement from the incident, dated 6-27-17. Staff A documented she received a phone call from a police officer at 1:43 p.m. and was asked if Tenant #1 was a current tenant at the Program. The officer explained to Staff A she was familiar with the tenant. The officer noticed the tenant wore a Wanderguard transmitter and immediately began contacting surrounding facilities. After receiving the call, Staff A immediately notified the Nurse at 1:45 p.m. She then notified the Director. They checked the alarm history and noted no indication of a breach at any door other than the front door and kitchen door. The daily event log indicated Tenant #1 present at 11:45 a.m. Another staff noted Tenant #1 present at lunch service until 12:45 p.m. Staff A noted at no point did the pagers alarm staff Tenant #1 exited the building.</p> <p>An interview with the Maintenance Director (MD) on 10-9-17 at 9:03 a.m. revealed Staff A</p>	A 138			

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A 138	<p>Continued From Page 7</p> <p>reported to him earlier in the day that the front door acted up; a wire that went into the magnet was loose. The MD repaired the door when Staff A received a call from police regarding Tenant #1. Staff A notified both the Nurse and the Former Director Tenant #1 was with police. The Nurse picked Tenant #1 up and brought him/her back to the building. They concluded Tenant #1 left the program while the main door alarm did not work, but the tenant's Wanderguard transmitter also failed to work. The MD reported he repaired the front door within 30 minutes of awareness it did not work appropriately.</p> <p>An interview with Staff B on 10-9-17 at 10:10 a.m. revealed Tenant #1 was present for lunch on the day of the elopement and was there at 12:45 p.m. Staff B confirmed staff pagers did not alert when Tenant #1 left and returned to the building.</p> <p>Tenant #1 left the building without staff knowledge on 6-27-17 after 12:45 p.m. and returned to the building at 2:00 p.m. The electronic wander device did not function as Tenant #1 left the building or when Tenant #1 was returned to the building. The front door, which was a delayed egress door, also failed to function appropriately for a time period on 6-27-17, the date Tenant #1 eloped. As a result, staff were not alerted when Tenant #1 left the building.</p>	A 138			

✓ 11/17/17 OK 11/17/17

**Plan of Correction
Iowa City Bickford Cottage**

A 089 481.69.26(4)a Service Plans

Regulatory Insufficiency: Program failed to develop service plans to reflect the identified needs of tenants.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Divisional Director of Resident Services provided the RNC re-education on Service Planning policy and development on 11/6/17.
- Resident #1 had evaluations completed and used to update and individualize their Service Plan to appropriately meet the resident's needs and preferences for assistance on 11/6/17.

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

- RNC will review Task Sheets, Incident/Accident Reports, Communication Book, Progress Notes and observe residents for significant changes that trigger the initiation of evaluations and Service Plan updates in order to meet the resident's changing needs/preferences for care.

The program will monitor performance to ensure compliance as follows:

- Divisional will audit resident records at least twice per year during onsite program visits to determine Service Plans have been developed that meet the resident's current needs.

Date deficiencies corrected by: 11/8/2017

A 138 481-69.32(2) Life Safety

Regulatory Insufficiency: Program failed to consistently ensure an operational door alarm system as required for a dementia-specific program.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Resident #1 was assigned a new functional resident monitoring system watch on 6/27/17. Maintenance Coordinator confirmed Resident #1's resident monitoring system watch was functional on 6/27/17.

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

- Maintenance Coordinator will check monitoring system alerts dashboard for functionality monthly.
- Maintenance Coordinator will complete exit door inspection report for resident monitoring door system weekly.

The program will monitor performance to ensure compliance as follows:

- Director will review the exit door inspection report weekly.
- Divisional will audit resident monitoring systems records at least twice per year during onsite program visits and as needed.

Date deficiencies corrected by: 11/8/2017