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
	S0011	A. BUILDING: _____ B. WING _____	C 07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE BURLINGTON	3301 STERLING DR BURLINGTON, IA 52601

(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	Initial Comments 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. General Population Number of tenants without cognitive disorder: 36 Number of tenants with cognitive disorder: 1 Memory Care Unit (if applicable) Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 6 TOTAL Census of Assisted Living Program for People with Dementia : 43 The following regulatory insufficiencies were cited during the investigation into Incident #83979-I.	A 000	See attached POC 8/23/19	
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 interview and record review, the program failed to provide appropriate care to 1 of 1 tenants (Tenant #1) identified as a result of program self-reported incident #83979-I. Finding follows: Record review on 7/17/19 revealed Tenant #1	A 013		

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A 013	Continued From page 1 was admitted to the program on 5/7/19. He was diagnosed with Dementia with behavioral disturbance. He was scored a Stage 5 on the Global Deterioration Scale which indicated moderately severe cognitive decline, according to a Cognitive Assessment dated 5/17/19. According to an Unusual Occurrence Report dated 5/23/19, Tenant #1 eloped from the building at 4:50 p.m. from the courtyard attached to the Memory Care Unit. The back-up RN received a call from an employee at a nearby school informing her she had seen Tenant #1 walking down the road. The school employee also notified Tenant #1's spouse she had seen Tenant #1. Tenant #1's spouse found Tenant #1 and returned him to the program. He was found 1.1 miles away and had crossed a highway before being found. Tenant #1 had no injuries resulting from the elopement. According to Wunderground.com, the temperature at the time of the elopement was 65 degrees with no precipitation. An Event Report for 5/23/19 noted "lock egress started" at the Courtyard Gate at 4:24 p.m., which would have indicated the door was no longer locked. The door was opened and closed again at 4:34 p.m. The Registered Nurse Coordinator reported during an interview on 7/18/19 at 8:20 a.m., she believed Tenant #1 left the building at 4:34 p.m. The door was not locked again until 4:58 p.m. According to the Event Report, Tenant #1 returned to the facility with his spouse at 5:08 p.m. Record review revealed Tenant #1's service plan, dated 5/7/19. According to the service plan, Tenant #1 ambulated independently with no can	A 013		

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A 013	Continued From page 2 or walker. Additional record review revealed the Program's unwitnessed door alarm procedure, revised 4-2014. According to the procedure, staff should check their pagers, perform a visual search inside and outside of door area, summon assistance, silence the alarm, initiate missing tenant procedure, and account for all residents. The procedure further directed, when a door alarm occurred, staff should visually search the inside and outside area surrounding the door that caused the alarm if it was unwitnessed. If no tenants were seen, staff should immediately summon the assistance of other staff to either look for the tenant whose watch activated the alarm or account for all tenants. Only after all staff have been made aware of the unwitnessed door alarm, should the alarm be silenced. An interview conducted with the back up RN on 7/17/19 at 11:40 a.m. revealed when she received the telephone call from the school employee she immediately left the building to look for Tenant #1. The back up RN looked around the school and enlisted others at the school to help her look for Tenant #1. She then went further down the street to look for Tenant #1. Someone drove up and notified her Tenant #1's spouse had found him. The back up RN said the weather was warm at the time of the elopement. She recalled Tenant #1's spouse was worried about him being hot as he had double layered his pants that day. When interviewed on 7/18/19 at 8:53 a.m. Staff D reported she worked on the locked memory care unit on the day of Tenant #1's elopement. Staff D recalled being outside the unit with some tenants in an attached courtyard until about 4:30 p.m. She then brought the tenants inside to assist	A 013		

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A 013	Continued From page 3 them with toileting. Staff D watched Tenant #1 walk towards his room and did not see him again until he was returned to the building at 5:08 p.m. According to Staff D, she did not carry a pager on which a notification would have been received when a tenant left the courtyard via the egress gate. Staff D did not hear an alarm on the courtyard gate until she went outside to check it at 4:58 p.m. When interviewed on 7/17/19 at 2:45 p.m. Staff C reported she also worked on 5/23/19. She reported there had been problems with the gate door at the courtyard since a storm on either May 18th or 19th. The pager had been going off notifying staff members the courtyard gate was open but it was not open. Staff C passed medication to other tenants in the program when the page was received about the gate door being opened and did not respond. When interviewed on 7/18/19 at 12:42 p.m. Staff E reported she worked 5/23/19. She said the pager had been receiving multiple notifications that day of the courtyard gate being opened so she didn't think much about it when the pager notified her the gate was open again. Staff E completed cares with another tenant and did not respond to check and see if any tenant had left the building. When interviewed on 7/18/19 at 3:50 p.m. the Director stated a page did go off notifying staff of the egress but no one responded to check the gate as the alarm had been going off all day.	A 013		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant.	A 037		

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A 037	Continued From page 4 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to fully evaluate tenants' needs. This pertained to 1 of 1 tenant identified as a result of program self-reported incident #83979-I (Tenant #1). Finding follows: Record review on 7/17/19 revealed Tenant #1 was admitted to the program on 5/7/19. He was diagnosed with Dementia with behavioral disturbance. He was scored a Stage 5 on the Global Deterioration Scale which indicated moderately servere cognitive decline, according to a Cognitive Assessment dated 5/17/19. Tenant #1 and his spouse met with his physician on 5/1/19, prior to admission into the program. According to the physician's Office/Clinic Notes, Tenant #1's dementia had continued to progress and he required 24 hour supervision due to	A 037		

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A 037	Continued From page 5	A 037		

confusion, wandering and being unable to be left alone. Tenant #1 had tried to leave the family home five times in one night. Sundowning behaviors had become a major issue, beginning around 3:00 PM. Physician's Admission Orders completed on that date identified Tenant #1 as ambulatory and prone to wandering.

Tenant #1 had Service Assessments dated 5/7/19 and 5/17/19. Neither service assessment addressed Tenant #1's wandering.

According to an Unusual Occurrence Report dated 5/23/19, Tenant #1 eloped from the building at 4:50 PM from the courtyard attached to the Memory Care Unit. The Back-up RN received a call from an employee at a nearby school informing her she had seen Tenant #1 walking down the road. The school employee also notified Tenant #1's spouse she had seen Tenant #1. Tenant #1's spouse found Tenant #1 and returned him to the program. He was found 1.1 miles away and had crossed a highway before being found. Tenant #1 had no injuries resulting from the elopment. According to Wunderground.com, the temperature at the time of the elopement was 65 degress with no precipitation.

The Assistant Director reported when Tenant #1 first moved to the program he would try the locked doors to get out. He also tried to follow his family out of the building.

During an interview conducted with the Back-up RN, she reported Tenant #1 tried to leave the program by pushing on the doors when he first arrived and still did so.

Staff A reported on 7/17/19 at 2:07 PM, Tenant #1

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A 037	Continued From page 6 had tried to go through the egress door but with redirection he did not do so as often. On 7/17/19 at 2:15 PM, Staff B reported Tenant #1 displayed some exit seeking behaviors such as pressing on exit doors when he first arrived at the program. During an interview with Staff C on 7/17/19 at 2:45 PM, she reported Tenant #1 always tried to get through doors. She didn't take Tenant #1 outside the building as she worried about him walking off. The Director and Registered Nurse Coordinator (RNC) were interviewed on 7/18/19 at 8:20 AM. The Director reported being aware Tenant #1's spouse had put five locks on their house doors to keep him inside. The RNC stated she believed Tenant #1 liked to walk but was not purposely attempting to leave the program. The RNC confirmed wandering behaviors were not addressed on Tenant #1's service assessment.	A 037		

OK 10/21/19

✓ 10/21/19

Plan of Correction
Burlington Bickford Cottage

A 013—481-67.3(2) Tenant Rights
Regulatory Insufficiency: Program failed to provide care to tenant identified as an elopement risk.

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

- RNC completed a Nursing Assessment, Service Assessment, Cognitive Assessment and a Service Plan update for Resident #1 on 8/17/19.

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

- Divisional Director of Resident Services provided re-education to the Director and RNC on Resident Bill of Rights, Missing Resident/Unwitnessed Door Alarm Policy on 08/20/19.
- Director/Designee will re-educate all staff members on the Resident Bill of Rights and Missing Resident/Unwitnessed Door Alarm Policy on 08/21/19. Those staff who are not in attendance shall be provided 1:1 education.
- Upon hire, the Director/Designee will provide education to new staff members on Resident Bill of Rights and Missing Resident/Unwitnessed Door Alarm Policy.

The program will monitor performance to ensure compliance as follows:

- Director/Designee will conduct Missing Resident/Unwitnessed Door Alarm drills monthly for 90 days ensuring each shift participates in a drill to ensure compliance.
- Director and/or RNC will provide individual education or counseling for staff members who are not compliant with implementing appropriate policy guidelines.
- Divisional will audit Missing Resident/Unwitnessed Door Alarm drills twice per year during onsite visits.

Date deficiencies corrected by: 08/23/19

A037—481-69.22(2) Evaluation of Tenant
Regulatory Insufficiency: Program failed to fully evaluate tenants' needs.

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

- RNC completed a Nurse Review, Nursing Assessment, Service Assessment, Cognitive Assessment and a Service Plan update for Resident #1 on 8/17/19.
- Divisional Director of Resident Service provided RNC re-education on Assessment Policy, Nurse Review Policy on 8/20/19.

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

- RNC will review Task Sheets, Incident/Accident Reports, Communication Book and observe tenants' for significant changes and complete evaluations as needed.

The program will monitor performance to ensure compliance as follows:

- Divisional will audit resident records at least twice per year during onsite visits and as needed to ensure that tenant needs were evaluated and Assessment process followed.

Date deficiencies corrected by: 8/23/19