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DEPARTMENT OF INSPECTIONS AND APPEALS

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0009 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 07/10/2017 |
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| NAME OF PROVIDER OR SUPPLIER BICKFORD COTTAGE MUSCATINE | STREET ADDRESS, CITY, STATE, ZIP CODE 2807 CEDAR ST MUSCATINE, IA 52761 |
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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>Dementia-Specific Program by Dedication</p> <p>Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 6 Total Population of Program at time of on-site: 7</p> <p>TOTAL census of Assisted Living Program: 41</p> <p>The following regulatory insufficiencies were cited during the Investigation of Complaints #67802-C, #67817-C & #69006-C.</p> | A 000 | <p>See attached</p> <div style="border: 1px solid black; border-radius: 50%; width: 150px; height: 100px; display: flex; align-items: center; justify-content: center; margin: 20px auto;"> <p>POC 8/31/17</p> </div> | |
| A 012 | <p>481-67.3(1) Tenant Rights</p> <p>481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the</p> | A 012 | | |

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| DIVISION OF HEALTH FACILITIES - STATE OF IOWA LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| A 012 | <p>Continued From page 1</p> <p>Program failed to consistently provide an environment of consideration and respect to tenants. This potentially affected all tenants residing at the program.</p> <p>Findings follow:</p> <p>1. During a community meeting on 6-20-17 at 11:00 a.m., five tenants attended and reported Tenant #2 frequently called out for help. After doing so for about three hours, it became upsetting to hear. Staff responded appropriately and would ask Tenant #2 what was needed, but the calling out would not stop. They reported Tenant #10, who used to work in a nursing home, would enter Tenant #2's apartment and ask Tenant #2 to be quiet; but two weeks ago Tenant #10 entered Tenant #2's apartment and yelled at Tenant #2 to "shut up."</p> <p>When interviewed on 6-14-17 at 3:00 p.m., Tenant #1 reported Tenant #2 said "Help, Help" about 40-50 times a minute, which he/she stated, "drives me up a wall." Tenant #1 reported this to be a real problem during the night when he/she tried to sleep. Tenant #1 had family bring in a fan and white noise machine to try to drown out the noise.</p> <p>2. When interviewed on 6-14-17 at 3:00 p.m., Tenant #1 also reported one night Tenant #13 walked into his/her apartment and said someone was coming. Tenant #13 wore only a shirt to mid thigh and carried a plastic clothes basket with dirty clothes. Tenant #13 sat the basket on a chair. Tenant #1 pulled the call cord and waited about 10 minutes for a staff to respond. After that incident, Tenant #1 started to lock the apartment door during the overnight hours to prevent other tenants from entering.</p> | A 012 | | |
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| A 012 | Continued From page 2 3. When interviewed on 6-22-17 at 12:55 p.m., Tenant #14 stated Tenant #3 started coming into his/her apartment in the middle of the night for the last two weeks. Tenant #3 would tell Tenant #14 to get up so he/she could go to bed. Tenant #14 reported this to staff and they responded, "Oh that's just (Tenant #3). He/She wanders at night." The incidents would occur around 1:30 a.m. and 2:30 a.m. and happened about ten different nights before Tenant #14 decided to lock his/her door. Tenant #3 continued to come and knock on the door during the night. Tenant #14 stated it was not fair to the tenants to have to endure this. Staff told Tenant #14 that Tenant #3 didn't know what he/she was doing, but Tenant #14 stated the rest of the tenants had to suffer for it. | A 012 | | |
| 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 interviews and record review, the Program failed to ensure tenants' rights to receive adequate and appropriate care, treatment and services. This affected 3 of 17 tenants reviewed (Tenants #1, #15 & #16). Findings follow | A 013 | | |

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| A 013 | <p>Continued From page 3</p> <p>1. Record review on 6-27-17 revealed an after visit summary for Tenant #15 from an Emergency Room visit on 6/22/17. The summary noted Tenant #15 diagnosed with open knee wounds. Tenant #15 was prescribed clindamycin 150 milligrams (mg), two capsules by mouth four times a day; and saccharomyces boulardii (probiotic) 250 mg two capsules two times daily. The report included information regarding cellulitis and instructed follow up with Tenant #15's primary care physician.</p> <p>Additional record review revealed Tenant #15 seen by his/her physician 6/26/17. According to the report, Tenant #15 sustained a fall and presented with scabs on both legs. The scabs became infected and had discharge from them. Tenant #15 tolerated antibiotics being taken. The physician assessed cellulitis of the left lower extremity and noted, "... cellulitis of both knees with eschar... It seems to be improving and the patient has no fever or chills. No extradite or swelling of the skin. The eschar seems to be receding." Plans included continuing antibiotic treatment and nurses monitoring the wounds.</p> <p>Tenant #15's physician orders, dated 6/2/17, revealed a diagnoses including : mild cognitive impairment, hyperlipidemia, hypertension, anemia, breast cancer, aortic valve sclerosis, osteopenia, idiopathic peripheral neuropathy, spinal stenosis, lesion of ulnar nerve. The orders also noted allergies to peanut oil. Treatments prescribed included TED hose on in the morning and off in the evening. Routine medications included Biofreeze Professional applied to the right knee</p> <p>When interviewed on 6-27-17 at 10:40 a.m., Staff N reported a couple weeks ago, after lunch, she</p> | A 013 | | |
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| A 013 | <p>Continued From page 4</p> <p>assisted Tenant #15 into the bathroom and noticed multiple bright red lines going from the ankles up to the abdomen in streaks of different sizes, stopping right below the navel. She had the Registered Nurse Coordinator (RNC) look at the streaks and asked if she should document what she observed. According to Staff N, the RNC stated it looked interesting, like an allergic reaction and no, Staff N didn't have to chart on this, the RNC would contact Tenant #15's family. Staff N heard the RNC talking to someone on the phone. At the end of Staff N's shift, around 2:30 p.m. to 2:45 p.m. Staff N checked on Tenant #15 and the streaks were not as bright as they initially were, nor were there as many lines of streaks. Tenant #15 did not complain of any pain or itching. Staff N stated a mounds bar dessert was served at lunch that day. She asked the kitchen if it had peanuts in it since Tenant #15 had an allergy to peanut oil and she was told, yes it had one half cup of peanut butter. A day or two later fluid blisters appeared on both knees; one on each knee, one was the size of a fifty cent piece and the other a little smaller. Tenant #15 wore thigh high anti-embolism stockings, but staff quit putting them on and stopped the Biofreeze due to the blisters. Staff N was aware Tenant #15 had gone to the ER 6/22/17, where he/she diagnosed with cellulitis and prescribed an antibiotic. She looked at Tenant #15's knees yesterday and they were red and pink, scabby looking.</p> <p>A review of Tenant #15's Medication Administration Record indicated staff held the application of Biofreeze to the right knee three times a day stating on 6-4-17 and had not restarted applying it. A review of Tenant #15's Treatment Administration Record indicated staff held the application and removal of thigh high anti-embolism stockings starting on 6-4-17 and</p> | A 013 | | |

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| A 013 | <p>Continued From page 5</p> <p>had not reapplied them.</p> <p>Continued review of Tenant #15's file did not reflect any documentation of Tenant #15 consuming a dessert with peanut butter, or any further follow up. Documentation of Tenant #15 sustaining a fall could not be located. The record failed to document any observation of red streaks on Tenant #15's legs, blister's to his/her knees, or further follow up. Documentation regarding observations and treatment by staff or a change of condition nursing assessment of Tenant #15's condition prior to or after the ER visit could not be located .</p> <p>When interviewed on 6-27-17 at 10:20 a.m., Staff M stated she was told Tenant #15 had an allergic reaction and directed not to apply his/her anti-embolism stockings or apply Biofreeze. She stated Tenant #15 was allergic to peanut oil and had been given an almond bar dessert that had a layer of crust, coconut and chocolate. After eating it Tenant #15's knees got splotchy. A couple days ago she noticed the knees looked bad; scabby, deep and red around the scab. Staff M told the med aide to tell the nurse. Staff M reported on 6/22/17 she applied Triple Antibiotic Ointment (TAO) to Tenant #15's knees as the scabs looked deep with redness around them. She stated she did not document this treatment. Since she was going to nursing school she figured it would be good to do so she took the ointment from the stock kept in the medication room. She stated there were no nurses in the building at the time. Staff M stated the next thing she knew, Tenant #15 went out to the ER the same night. When Tenant #15 stood up, it was painful on the knees. Staff M was told the next day Tenant #15 had cellulitis and was on an antibiotic.</p> | A 013 | | |

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| A 013 | <p>Continued From page 6</p> <p>When interviewed on 6-27-17 at 10:04 a.m., Staff I, an LPN, stated about a week ago she noticed pea sized scabs on both knees of Tenant #15. She had not worked for about five days so asked Staff B what was going on, Staff B informed her it was due to an allergic reaction. She stated Tenant #15 had not been wearing anti-embolism stockings for a couple weeks, nor receiving BioFreeze treatment on knees since the affected areas were identified. She stated there was no current treatment to Tenant #15's knees.</p> <p>When interviewed on 7-10-17 at 9:53 a.m. the RNC stated staff reported a rash on Tenant #15's knee. She observed the knee and observed a flat, not raised rash. Staff were concerned Tenant #15 may have eaten some peanut butter as the tenant was allergic to peanut butter. Tenant #15 did not report any itching or shortness of breath and felt fine. On the weekend, staff reported to the RNC Tenant #15's knee had blisters. The RNC observed the area on Monday and stated it was fine, blisters were gone, very little redness and everything else disappeared. The RNC reviewed the Progress Notes for May and June in Tenant #15's file and confirmed there was no documentation regarding Tenant #15's condition, observations or treatment.</p> <p>2. Tenant #16's file was reviewed. According to an Incident Report dated 4-16-17, Tenant #16 came up to Tenant #14 in the general living room and started yelling at Tenant #14 for sitting in Tenant #16's chair. Tenant #14 told Tenant #16 to shut up and in that instant Tenant #16 pushed Tenant #14 in the shoulder. Tenant #14 denied any pain.</p> <p>According to an Incident Report dated 5-29-17,</p> | A 013 | | |
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| A 013 | <p>Continued From page 7</p> <p>staff overheard a loud argument in the general living room, they responded and witnessed Tenant #16 and Tenant #17 in a boxing stance with their fists raised. Staff had the tenants sit down and asked Tenant #17 what happened. Tenant #17 stated we got into an argument and Tenant #16 kicked my shin and pinched my shoulder. Tenant #17 leaned out of the way and the chair Tenant #17 was in tipped over. Tenant #16 stated a profanity at Tenant #17. Tenant #16 had a small cut on left knuckle.</p> <p>According to an Incident Report dated 6-19-17, Tenant #16 was in an argument with Tenant #17 about sitting next to Tenant #16 in the living room. Tenant #17 told Tenant #16 not to boss Tenant #17 around, at which point Tenant #16 grabbed Tenant #17's arm and pushed Tenant #17 several times. There was no documentation regarding Tenant #17's condition after being grabbed.</p> <p>According to a Fax to Tenant #16's physician dated 5-29-17, a new order was received indicating Tenant #16 needed either a neurology or psych evaluation.</p> <p>According to the Progress Notes dated 6-13-17, Tenant #16's family was notified of the order for a neurology or psych evaluation. Family responded they were out of town and would take care of the appointment the following week. No further documentation of an appointment was evident in Tenant #16's file as of 6-27-17. According to Tenant #16's service plan dated 2-13-17, Tenant #16 needed verbal reminder and redirection when behavior was inappropriate.</p> <p>3. When interviewed on 6-14-17 at 3:00 p.m., Tenant #1 stated since admission, 13 days earlier, he/she had not received a shower. Staff</p> | A 013 | | |
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| A 013 | Continued From page 8 only assisted Tenant #1 to and from the dining room for meals. A couple days earlier Tenant #1 had a bowel accident and requested assistance with a shower. Staff offered Tenant #1 a wash cloth while in the bathroom and told him/her to wash his/her arm pits and use a peri-cloth. Staff assisted Tenant #1 to put on clean clothes and told him/her to go to breakfast. No one ever came back later to assist Tenant #1 with a shower, and he/she could not shower alone. Tenant #1 reported upon admission he/she requested a shower every couple days and also needed help putting on pants, shoes and socks. When interviewed on 6- 20-17 at 2:47 p.m., the Director reported task sheets were not retained for longer than about one week. Review of available task sheets from 6-12-17 through 6-18-17 revealed no documentation of Tenant #1 provided a shower. Tenant #1 was discharged on 6-14-17. | A 013 | | |
| A 064 | 481-67.9(4)g Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, | A 064 | | |

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| A 064 | <p>Continued From page 9</p> <p>functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, the Program's nurse and staff failed to document observation of a tenant's change in condition, withholding of treatments, and application of treatments that were not prescribed. This affected 1 of 1 tenant identified as a result of 69006-C (Tenant #15).</p> <p>1. Review of Tenant #15's file revealed the following:</p> <p>a. An After Visit Summary from the ER, dated 6-22-17, documented Tenant #15 treated for an open knee wound. Care instructions for cellulitis were included. Tenant #15 received orders for an antibiotic four times a day for four days and a probiotic.</p> <p>b. Physician visit record, dated 6-26-17, revealed Tenant #15 followed up with primary physician regarding the ER visit. The physician record indicated Tenant #15 had a fall and scabs on both legs, they became infected and had a discharge from them.</p> <p>Tenant #15's file failed to include documentation prior to the ER visit to a possible fall or any change in condition.</p> <p>When interviewed on 6-27-17 at 10:40 a.m., Staff N stated a couple weeks prior, she assisted</p> | A 064 | | |

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| A 064 | <p>Continued From page 10</p> <p>Tenant #15 into the bathroom after lunch and noticed multiple bright red lines going from the ankles up to the abdomen in streaks of different sizes, stopping right below the navel. She had the Registered Nurse Coordinator (RNC) look at the streaks and asked if she should document what she observed. According to Staff N, the RNC stated it looked interesting, like an allergic reaction and no, Staff N didn't have to chart on this, the RNC would contact Tenant #15's family. At the end of Staff N's shift, around 2:30 p.m. to 2:45 p.m. Staff N checked on Tenant #15 and the streaks were not as bright at initially observed, nor were there as many lines of streaks. Tenant #15 did not complain of any pain or itching. Staff N stated a mounds bar dessert was served at lunch that day. She asked the kitchen if it had peanuts in it since Tenant #15 had an allergy to peanut oil and she was told, it had one half cup of peanut butter. A day or two later fluid blisters appeared on both knees; one on each knee, one was the size of a fifty cent piece and the other a little smaller. Tenant #15 wore thigh high anti-embolism stockings but staff quit putting them on and stopped the Biofreeze due to the blisters. Staff N was aware Tenant #15 had gone to the ER 6/22/17. She reported Tenant #15 diagnosed with cellulitis and given a prescription for an antibiotic. She looked at Tenant #15's knees yesterday and noted them to be red and pink, scabby looking.</p> <p>When interviewed on 6-27-17 at 10:20 a.m., Staff M stated she was told Tenant #15 had an allergic reaction and not to put on the anit-embolism stockings or apply the Biofreeze. She stated Tenant #15 was allergic to peanut oil and had been given an almond bar dessert that contained peanut butter. After eating it Tenant #15's knees became splotchy. She noticed the knees looked</p> | A 064 | | |
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| NAME OF PROVIDER OR SUPPLIER BICKFORD COTTAGE MUSCATINE | STREET ADDRESS, CITY, STATE, ZIP CODE 2807 CEDAR ST MUSCATINE, IA 52761 |
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| A 064 | <p>Continued From page 11</p> <p>bad, which she described as scabby, deep and red around the scab. Staff M told the med aide to tell the nurse. On 6/22/17 she applied Triple Antibiotic Ointment (TAO) to Tenant #15's knees, as the scabs looked deep with redness around them. When Tenant #15 stood up, it was painful on the knees. She stated she did not document this treatment. Since she was going to nursing school she figured it would be good to do so she took the ointment from the stock kept in the medication room. She stated there were no nurses in the building at the time. Staff M stated Tenant #15 had been sent to the ER 6/22/17. The next day, she was informed Tenant #15 had cellulitis and was on an antibiotic. Coordinator (RNC) had never told her she could apply TAO.</p> <p>When interviewed on 6-27-17 at 10:04 a.m., Staff I, an LPN, stated about a week prior she noticed pea size scabs on both knees of Tenant #15. She had not worked for about five days, so asked Staff B what was going on, Staff B said it was due to an allergic reaction. She stated Tenant #15 had not been wearing antiembolism stockings for a couple weeks, nor receiving BioFreeze treatment on knees since the affected areas were identified. She stated there was no current treatment to Tenant #15's knees.</p> <p>When interviewed on 7-10-17 at 9:53 a.m. the RNC stated staff reported a rash on Tenant #15's knee. She observed the knee and observed a flat, not raised rash. Staff were concerned Tenant #15 may have eaten some peanut butter, as the tenant was allergic. Tenant #15 did not report any itching or shortness of breath and felt fine. On the weekend, staff reported to the RNC Tenant #15's knee had blisters. The RNC observed the area on Monday and stated it was fine, blisters were gone, very little redness and everything else</p> | A 064 | | |
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| A 064 | Continued From page 12 disappeared. The RNC reviewed the Progress Notes for May and June in Tenant #15's file and confirmed there was no documentation regarding Tenant #15's condition, observations or treatment. | A 064 | | |
| A 037 | 481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 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 interviews and record review, the Program failed to complete evaluation of tenants as warranted with a significant change. This affected 1 of 1 tenant identified as a result of 69006-C (Tenant #15). Findings follow: 1. Record review revealed Tenant #15's file included an After Visit Summary from the | A 037 | | |

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| A 037 | <p>Continued From page 13</p> <p>ER,dated 6-22-17. The summary documented Tenant #15 treated for an open knee wound. Care instructions for cellulitis were included. New orders for an antibiotic four times a day for four days and a probiotic were ordered.</p> <p>Additional record review revealed a physician visit record, dated 6-26-17, documented Tenant #15 followed up with primary physician regarding the ER visit. The physician record indicated Tenant #15 had a fall and scabs on both legs. The areas became infected and had discharge from them. Tenant #15 was tolerating the antibiotic. Functional, cognitive and health evaluations were not completed with a change of condition.</p> <p>Continued record review revealed functional, cognitive and health evaluations not completed when Tenant #15 had significant change of condition: prior to the ER visit when red streaks, fluid blisters and scabs were observed by staff and the withholding of anti-embolism stockings and non-application of Biofreeze. Further review revealed functional, cognitive and health evaluations not completed when Tenant #15 had significant change of condition after the ER visit with the addition of an antibiotic to treat cellulitis.</p> <p>When interviewed on 7-10-17 at 9:53 a.m. the RNC confirmed there was no documentation regarding Tenant #15's condition, observations, or treatment after change in condition noted.</p> | A 037 | | |
| A 047 | <p>481-69.23(1)i Criteria for Admission/Retention of Tenants</p> <p>481-69.23(231C) Criteria for admission and retention of tenants.</p> <p>69.23(1) Persons who may not be admitted</p> | A 047 | | |

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| A 047 | <p>Continued From page 14</p> <p>or retained. A program shall not knowingly admit or retain a tenant who:</p> <p>i. Requires maximal assistance with activities of daily living; or</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews and observations, the Program failed to discharge tenants who exceeded the criteria for admission and retention for a tenant who required maximal assistance with activities of daily living. This affected 2 of 17 tenants reviewed (Tenants #4 and #5).</p> <p>Findings follow:</p> <p>1. Observations revealed the following:</p> <p>a. On 6-20-17 at 11:30 a.m., Staff D wheeled Tenant #4 into the bathroom. While Tenant #4 sat in the wheelchair, Staff D lifted Tenant #4 into a standing position and place Tenant #4's left hand on the bathroom bar by the toilet. While cuing Tenant #4 to place right hand on the bar, Tenant #4 became stiff and uncooperative and Staff D was unable to place the hand and continue to hold onto Tenant #4. Staff E, assisted and held onto Tenant #4 as both staff pivoted and placed Tenant #4 onto the toilet. A clean protective undergarment was put in place with the assistance of Staffs D and E. Tenant #4 was handed a wash cloth and asked to wash face. Tenant #4 did not appear to understand what to do with the wash cloth and dropped it on the floor. Staff attempted to provide a hair brush and asked Tenant #4 to brush hair, Tenant #4 did not take the brush. Staff E stated there was no tooth</p> | A 047 | | |
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| A 047 | <p>Continued From page 15</p> <p>brush as Tenant #4 did not have teeth to brush. Staffs D and E stated hospice provided the showers, but two staff were needed to assist hospice in transferring Tenant #4 to a shower chair and transferring in and out of the shower. Tenant #4 was not able to wash self or follow directions during the shower. Staff was required to pick out clothing and dress Tenant #4, as Tenant #4 did not participate in dressing or following directions to lift arms. Staff D stated Tenant #4 used to ambulate but was wheelchair bound now and depending on if it was a good day or bad day, needed one or two staff to assist with transfers and pivoting. Tenant #4 needed assistance with eating but could feed self sometimes. Tenant #4 was not able to participate in toileting, peri-care, using a washcloth to bathe self, brush hair, dress self or transfer self without the assistance of one to two staff.</p> <p>b. On 6-20-17 at 3:55 p.m., Tenant #4 was observed sitting in a chair holding a doll. Staff K offered Tenant #4 a prepared wash cloth and directed Tenant #4 to wash face. Tenant #4 did not take the wash cloth and was not able to follow the directions given. Tenant #4 was offered a hair brush. Tenant #4 did not take the brush, Staff K placed it in hand but Tenant #4 was unable to follow directions in how to use the brush. Staffs J & K stated Tenant #4 was not able to participate in any Activities of Daily Living (ADL's). Tenant #4 was not able to participate in bathing or showers, toileting, personal hygiene, dressing or ambulation. Tenant #4 required the assist of two to toilet as Tenant #4 was unable to pull down pants or provide own peri-care. Tenant #4 no longer ambulated but could stand with assistance of two. Tenant #4 was transported in a wheelchair and then transferred to other chairs.</p> | A 047 | | |
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| A 047 | <p>Continued From page 16</p> <p>c. On 6-22-17 at 12:10 p.m., Tenant #4 was observed sitting at a dining room table, picking up a bowl of fruit and setting it back down and pulling at the table cloth. Tenant #4 would pick up a fork and stab at the tablecloth. A divided plate of food filled with meatloaf, mashed potatoes and mixed vegetables was prepared, staff cut the meat and gave the plate to Tenant #4. After several minutes, Tenant #4 stated to eat the mashed potatoes with fingers. Staff directed Tenant #4 to stop holding the tablecloth and to hold a fork. Tenant #4 held a fork in left hand although Tenant #4 is right handed and placed the empty fork in mouth. Staff E stated there were more days that Tenant #4 was unable to participate in ADL's than days when Tenant #4 did participate. Some days Tenant #4 would hold a washcloth but was unable to brush hair or teeth. Once in awhile Tenant #4 could put arms in a shirt but not very often anymore. Staff E stated Tenant #4 could usually feed self but needed hand over hand to get started. At 12:50 p.m., the monitor observed Tenant #4's plate and approximately 45 % of the food had been consumed.</p> <p>Record review of Tenant #4's record revealed the following:</p> <p>a. Tenant #4 had a diagnosis of dementia, resided in the locked dementia unit and was staged at a four (4) on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. Tenant #4 received hospice services.</p> <p>b. Service plan, dated 4-26-17, indicated staff would assist with cutting food into bite size pieces before bringing the food to the table. Tenant #4 used a scoop plate (a plate with deeper sides) to assist with getting the food on the silverware. Tenant #4 needed assistance with opening</p> | A 047 | | |
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| A 047 | <p>Continued From page 17</p> <p>packets and putting jelly on toast. Tenant #4 required a wake up call daily. Staff picked out clothing for the day and assisted with dressing. The tenant would put arm through the sleeves of top but this would vary from day to day. Staff assisted with putting on shoes and socks daily and applying fresh protective undergarments throughout the day. Staff would need to assist getting out of clothes and putting on night wear. Staff would verbally cue while guiding limbs through clothing as well as staff needing to button or zip clothing as needed. Staff assisted Tenant #4 into bed and pulled up the covers. Tenant #4 was incontinent of urine, occasionally of bowels and needed assistance with incontinence cares and peri area cleansing. Staff assisted Tenant #4 to the toilet upon rising, before and after meals, at bedtime and as needed. Staff assisted with putting on clean protective undergarments. Hospice assisted with a shower twice a week and staff would bathe as needed. Staff was to hand Tenant #4 a washcloth and give cues/prompts to wash own face. Staff to assist with washing of arms, legs, back, peri area and washing of hair. Staff was to assist Tenant #4 up with the assist of one, at times would need assist of two. The service plan indicated Tenant #4 was slow with ambulating and to allow time to ambulate. Use of a wheelchair was needed for longer distances or if tired. Tenant #4 required physical assist of one to two staff and wheelchair transport in case of an emergency.</p> <p>On 6-22-17 at 2:35 p.m., Hospice Nurse #1 was interviewed and stated she assisted Tenant #4 with a shower one time. Tenant #4 was unable to bathe self, could not brush teeth or hair. Due to right arm pain, which Tenant #4 guarded, Tenant #4 was not able to assist with dressing. Tenant #4 could feed self at times. Tenant #4 no longer</p> | A 047 | | |
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| A 047 | <p>Continued From page 18</p> <p>ambulated but transferred by pivoting with the assistance of one staff but if a bad day, needed two staff to assist.</p> <p>On 6-13-17 at 3:15 p.m., Staff C was interviewed and stated Tenant #4 required two staff to transfer, two staff to get in and out of bed and two staff to assist with toileting although Tenant #4 could wipe self. She stated Tenant #4 only walked when he/she wanted to walk.</p> <p>On 6-14-17 at 2:35 p.m., Staff D was interviewed and stated Tenant #4 had good days but a lot of the time two staff were needed to help Tenant #4 stand. Toileting Tenant #4 always took two staff. She stated Tenant #4 could hold the grab bar but could not wipe self.</p> <p>On 6-14-17 at 1:17 p.m., Staff B was interviewed and stated Tenant #4 required two staff to get up and for transfers. She stated Tenant #4 could not assist with dressing, brushing teeth or hair and did not participate in ADL's.</p> <p>On 6-20-17 at 9:36 a.m., Staff E stated Tenant #4 was getting close to exceeding care, Tenant #4 used to walk but now just used a wheelchair. Sometimes Tenant #4 used the grab bar while toileting.</p> <p>On 6-22-17 at 2:10 p.m., Staff J was interviewed and stated sometimes Tenant #4 could assist with dressing and had good and bad days. She stated Tenant #4 was unable to assist with transfers or participate in ADL's.</p> <p>Staffs B, C, D, I and J confirmed Tenant #4 exceeded level of care.</p> <p>2. Observations revealed the following:</p> | A 047 | | |
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| A 047 | Continued From page 19 a. On 6-20-17 at 3:35 p.m., the monitor observed Staff K tell Tenant #5 it was time to go to the bathroom. Tenant #5 was lying in bed, covered with blankets. Tenant #5 was unable to sit up alone, thus was assisted to the edge of the bed. A gait belt was put in place. Tenant #5 was not able to follow commands, when asked to raise arm. Tenant #5 was asked to stand up but assistance was needed. Tenant #5 could not ambulate alone and leaned backwards while Staff K assisted with ambulation. Tenant #5 took approximately 12 steps and knees started to buckle, thus, Staff J assisted in order to continue walking into the bathroom. Tenant #5 was unable to pull down protective undergarments so staff pulled them down. Staff changed the protective undergarment while Tenant #5 sat on the toilet. A mouth swab was offered but Tenant #5 would not grasp the swab or use it. Tenant #5 was given a hair brush and asked to brush hair. Tenant #5 held on to the brush for a few seconds and let go, dropping it to the floor. Staff stated Tenant #5 could not speak but expressed some emotions with facial expressions. A warm washcloth was offer but staff needed to place in Tenant #5's hand and directed Tenant #5 to wash face but was unable to do so. Staff put pants on over the protective undergarment without any assistance from Tenant #5. Tenant #5 did not raise legs or follow commands to assist. Shoes were put on. Tenant #5 was informed staff were going to stand Tenant #5, two staff assisted in standing and two staff were needed to pull up pants. Staffs J and K stated Tenant #5 always had to be fed. b. On 6-22-17 at 11:46 a.m., the monitor observed Tenant #5 asleep in a living room chair. Tenant #5's family arrived and physically assisted Tenant #5 up from the chair. The family stated | A 047 | | | |

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| A 047 | <p>Continued From page 20</p> <p>they had to hold Tenant #5 to assist in ambulation. Tenant #5 was observed walking on the tips of toes, heels not touching the ground with family holding Tenant #5. When arriving at the dining room chair, family turned Tenant #5 around while staff assisted onto the chair at the table. Tenant #5 was observed leaning to the left side while seated. Tenant #5's family fed Tenant #5. Family stated Tenant #5 used to be able to eat finger foods but it had been more than a year since that occurred. Family had been coming to feed Tenant #5 all three meals each day for over a year. Family stated Tenant #5 was unable to hold a glass to drink, so family held the glass and raised it to mouth.</p> <p>Record review of Tenant #4's record revealed the following:</p> <p>a. Tenant #5 had a diagnosis of anxiety and Alzheimer's, resided in the locked dementia unit and was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #5 was admitted to hospice on 5-10-17.</p> <p>b. Tenant #5's Service plan indicated he/she could eat finger foods by self and family assisted with meals. Verbal reminders were required of meal times and assistance with packets and frequent reminders to eat. Due to cognitive decline, staff needed to assist to bathroom in the morning, before and after meals and at bedtime and as needed throughout the shifts. Tenant #5 wore a brief and would need assistance in changing as need while providing good peri care and application of a barrier cream as needed. Hospice provided a shower one to two times a week, Tenant #5 could assist minimally with washing but staff to wash back and hair. Staff needed to assist with all hygiene and grooming</p> | A 047 | | |
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| NAME OF PROVIDER OR SUPPLIER BICKFORD COTTAGE MUSCATINE | STREET ADDRESS, CITY, STATE, ZIP CODE 2807 CEDAR ST MUSCATINE, IA 52761 |
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| A 047 | <p>Continued From page 21</p> <p>tasks. Due to cognitive decline, staff to assist with all mobility. The majority of time would walk with a gait belt and staff assistance but may need the wheelchair when tired.</p> <p>On 6-22-17 at 11:55 a.m., Staff E was interviewed and stated sometimes Tenant #5 used to be able to put arm into a shirt but not any more. Tenant #5 was unable to assist with dressing or brushing hair or teeth. Hands were too shaky and jerky so Tenant #5 could not longer assist. Tenant #5 could not assist with wiping self or peri care during toileting. Tenant #5 was non verbal, but on occasion would say one or two words. Hospice assisted with showers, staff and the hospice aide would transfer to shower chair and staff would hold Tenant #5 while hospice dried Tenant #5 off after the shower. Tenant #5 could not dress self, even with assistance. Tenant #5 had a toothbrush but was unable to hold the brush, so Staff E brushed the teeth. Tenant #5 was unable to brush hair, so staff brushed hair. Tenant #5 would hold a wash cloth if given but no longer made any motions to wash self. Staff E stated Tenant #5 was unable to participate in all ADL's. Staff E stated if family or others were unable to be there to feed Tenant #5, staff would feed but that had never happened.</p> <p>On 6-22-17 at 2:35 p.m., Hospice Nurse #1 was interviewed and stated Tenant #5 could absolutely not participate in any ADL's. Full assist was required with showers and Tenant #5 could not assist with dressing, brushing teeth or hair. Tenant #5 had contractions due to Parkinson's which did not allow Tenant #5 to move legs to ambulate. Tenant #5 would stand and need to be put into a wheelchair. She stated Tenant #5's family fed Tenant #5 all three meals as Tenant #5 was unable to feed self.</p> | A 047 | | |
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| A 047 | <p>Continued From page 22</p> <p>On 6-14-17 at 1:17 p.m., Staff B was interviewed and stated Tenant #5's knees gave out even when using a gait belt so two staff were needed for toileting. She stated one staff was required to assist with shower and grooming but Tenant #5 didn't do anything in regards to cares, staff had to do it all.</p> <p>On 6-20-17 at 1:50 p.m., Staff I was interviewed and stated Tenant #5 was a two person assist. Tenant #5 could not pull pants down, did not hold onto the bar in the bathroom but may grip if staff placed hand on bar. Tenant #5 would fling body forward making it hard to assist and Tenant #5 could not brush hair or teeth. Staff used moist swabs after every meal due to Tenant #5 pocketing food. Tenant #5 was usually incontinent even with every two hour toileting.</p> <p>On 6-20-17 at 2:20 p.m., Staff D was interviewed and stated she could assist Tenant #5 by herself but it was nice to have two staff especially for peri-care in the bathroom. Tenant #5 wouldn't wash face or hands, could not brush teeth or hair. Family fed Tenant #5 for all three meals and usually did all the walking. Hospice performed showers but two staff were needed to get Tenant #5 in and out of the shower, although one staff could do the shower.</p> <p>On 6-22-17 at 2:10 p.m., Staff J was interviewed and stated Tenant #5 could not participate in any ADL's, could not follow directions for dressing or any other ADL's, unable to wipe self after toileting or to perform peri care.</p> <p>Staffs #B, D, I and J confirmed Tenant #5 exceeded level of care.</p> | A 047 | | |
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| A 089 | Continued From page 23 | A 089 | | |
| 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 interviews, record reviews and observations, tenant service plans were not individualized to identify tenant's needs and preferences for assistance. This affected 4 of 17 tenants reviewed (Tenants #1, #2, #15 & #16). Findings follow:</p> <p>1. Record review revealed Tenant #1's service plan, dated 5-31-17, indicated staff were to assist him/her in and out of the shower for safety. Tenant #1 used a shower bench to sit on with showers for balance and safety. Staff were to assist with washing of back and lower legs. Tenant #1 could wash the rest of self. Staff were to assist with drying off. Assistance with bathing was needed one to two times a week.</p> <p>Further review of the service plan indicated Tenant #1 liked to sleep in recliner. The service plan also indicated staff should strip his/her bed and remake with clean sheets weekly.</p> <p>When interviewed on 6-14-17 at 2:52 p.m., Staff A indicated concern due to staff not providing showers or laundry assistance for Tenant #1 since admission 13 days prior.</p> | A 089 | | |

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| A 089 | <p>Continued From page 24</p> <p>When interviewed on 6-14-17 at 3:00 p.m., Tenant #1 stated no bathing assistance had been provided during the 13 days he/she resided at the Program. Upon admission, Tenant #1 stated he/she informed the Program showers were desired every couple days. Tenant #1 slept in a recliner. The monitor observed Tenant #1 sitting in a recliner in his/her apartment. There was no bed in Tenant #1's apartment.</p> <p>When interviewed on 6-20-17 at 2:47 p.m., the Director was unable to provide documentation of shower services when requested. The Director stated documentation regarding shower services was part of the staff task sheets and were not retained longer than about one week. The monitor reviewed staff Task Sheets that were available from 6-12-17 through 6-18-17. Tenant #1 was discharged on 6-14-17. There was no documentation of a shower being provided for Tenant #1.</p> <p>2. Observations on 6-13-17, 6-14-17 and 6-22-17 revealed Tenant #2 seated in the living room, calling out "help, help" for on an ongoing period of time. Staff asked Tenant #2 if he/she needed anything. Once staff left the area, the calling out continued.</p> <p>Record review revealed Tenant #2's service plan dated 5-9-17, documented Tenant #2's behavior was appropriate. Tenant #2 would yell "help, help" if he/she required staff assistance and needed their attention. The plan instructed staff to reassure the tenant they were checking on him/her and encourage him/her to use the call light for assistance. Staff could also offer Tenant #2 a cup of coffee and/or snack.</p> | A 089 | | |
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| A 089 | <p>Continued From page 25</p> <p>When interviewed on 6-14-17 at 3:00 p.m., Tenant #1 stated Tenant #2 said "Help, Help" about 40-50 times a minute. Tenant #1 reported the behavior to be irritating, and stated it was particularly a problem during the night when he/she tried to sleep. Tenant #1 had family bring in a fan and white noise machine to try to drown out the noise.</p> <p>On 6-20-17 at 11:00 a.m., during a community meeting five tenants reported Tenant #2 constantly called out for help. After doing so for about three hours it became upsetting to hear. The tenants stated staff responded appropriately and would ask Tenant #2 what was needed, but the calling out would not stop. A tenant commented it was frustrating to watch a movie in the living room when Tenant #2 constantly called out for help.</p> <p>Staffs B, C, D, E, F, H and I were interviewed and confirmed Tenant #2 regularly yelled out, "help, help." Staff reported this behavior to be upsetting to other tenants. Staff B stated it upset other tenants, especially during the night. Staff E indicated Tenant #2 called out quite frequently and it had become a habit since Tenant #2 had been at a rehab center. The yelling upset other tenants, especially if they tried to watch television. Tenant #2 needed to be reminded not to say it. If Tenant #2 was ignored the yelling would increase.</p> <p>When interviewed on 6-20-17 at 2:47 p.m., the Director stated Tenant #2 called out sometimes, but hospice had increased a medication to address this. She stated staff just needed to respond to Tenant #2's requests.</p> <p>3. Record review revealed Tenant #15's After Visit Summary from the emergency room (ER),</p> | A 089 | | |

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| A 089 | <p>Continued From page 26</p> <p>dated 6-22-17, documented Tenant #15 treated for an open knee wound. Care instructions for cellulitis were included. New orders for an antibiotic four times a day for four days and a probiotic were ordered.</p> <p>According to a physician visit record dated 6-26-17, Tenant #15 followed up with primary physician regarding the ER visit. The physician record indicated Tenant #15 had a fall and scabs on both legs. The wounds were infected and had a discharge from them.</p> <p>Continued record review revealed Tenant #15's service plan not updated to reflect his/her current condition and addition of antibiotic and probiotic medications.</p> <p>4. Record review of Tenant #16's record revealed the following:</p> <p>a. Incident Report, dated 4-16-17, documented Tenant #16 went up to Tenant #14 in the general living room and started yelling at Tenant #14 for sitting in his/her chair. Tenant #14 told Tenant #16 to shut up and in that instant Tenant #16 pushed Tenant #14 in the shoulder. Tenant #14 denied any pain.</p> <p>b. An Incident Report, dated 5-29-17, documented staff overheard a loud argument in the general living room. Staff responded and witnessed Tenant #16 and Tenant #17 in a boxing stance with their fists raised. Staff had the tenants sit down and asked Tenant #17 what happened. Tenant #17 stated they got into an argument and Tenant #16 kicked his/her shin and pinched his/her shoulder. Tenant #17 leaned out of the way and his/her tipped over. Tenant #16 stated a profanity at Tenant #17. Tenant #16 had</p> | A 089 | | |
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| A 089 | <p>Continued From page 27</p> <p>a small cut on left knuckle.</p> <p>c. An Incident Report, dated 6-19-17, documented Tenant #16 in an argument with Tenant #17 about sitting next to him/her in the living room. Tenant #17 told Tenant #16 not to boss him/her around, at which point Tenant #16 grabbed his/her arm and pushed him/her several times. There was no documentation regarding Tenant #17's condition after being grabbed.</p> <p>d. A Fax to Tenant #16's physician, dated 5-29-17, noted a new order received indicating Tenant #16 needed either a neurology or psych evaluation.</p> <p>e. Progress Notes, dated 6-13-17, noted Tenant #16's family notified of the order for a neurology or psych evaluation. Family responded they were out of town and would take care of the appointment the following week. No further documentation of an appointment was evident in Tenant #16's file as of 6-27-17.</p> <p>f. Tenant #16's service plan, dated 2-13-17, indicated Tenant #16 needed verbal reminder and redirection when behavior was inappropriate. Tenant #16's service plan was not updated to reflect tenant to tenant behaviors, interventions and treatment as prescribed by the physician.</p> | A 089 | | |



August 14th, 2017

Linda Kellen, Bureau Chief
Adult Services Bureau
Health Facilities Division
Lucas State Office Building
321 East 12th St.
Des Moines, IA 50319-0083
Tenant

Dear Ms. Kellen:

This letter is in response to the Complaint # 67802-C, #67817-C & #69006-C investigated from 06/13/2017 – 07/10/2017 at Muscatine Bickford Cottage.

The following document will serve as the written Plan of Correction addressing the regulatory insufficiencies identified during the visit.

If you have any additional questions and/or concerns, please feel free to contact me at 563-263-6600.
Sincerely,

Mindy Rowe, Director
Muscatine Bickford Cottage



✓ 8/21/17

OK 8/21/17

**Plan of Correction
Muscatine Bickford Cottage**

A 012 481-67.3(1) Tenant Rights

Regulatory Insufficiency: Program failed to consistently provide an environment of consideration and respect to tenants.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #1 no longer lives at Bickford as of 6/14/17
- Medication adjustments were initiated for Tenant #2 directed by the RN Coordinator, per physician order in consultation with Hospice RN.
- Tenant #3 was transferred to a Specialized Dementia Care unit within the facility. RN Coordinator will monitor and assess for significant change as needed.

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

- The Director or RN Coordinator will ask residents monthly during Resident Council meetings for any concerns or issues.
- Director will re-educate all staff members on the Resident Bill of Rights and the Communication Policy on 8/31/17.
- RNC will reassess residents for interventions or appropriateness when their behaviors infringe on the rights of other residents.

The program will monitor performance to ensure compliance as follows:

- RNC will interview residents during the assessment process regarding any concerns/issues and report them to the Director for investigation and follow up.

Date deficiencies corrected by: 08/31/2017

A013 481-67.3(2) Tenant Rights

Regulatory Insufficiency: Program failed to ensure tenants' rights to receive adequate and appropriate care, treatment and services.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #15 was assessed by the physician on 6/29/17 and continues to be followed by the physician as needed. RNC directs/delegates resident's care per physician orders.
- RN Coordinator performed a Nursing Assessment, Cognitive Assessment, Service Assessment and a Service Plan update for Tenant #16 on 7/31/17. Tenant #16 has a consultation with a psychologist on 8/24/17. RNC will direct/delegate care per psychologist orders.



- Director and/or RNC will re-educate Staff N, M and I on the Incident/Accident Reporting Policy, Fall Investigation, Communication Policy and Documentation Policy on 8/31/17.

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

- Divisional Director of Resident Services will provide re-education on 8/18/17 to the Director and RNC on the Incident/Accident Reporting Policy, Fall Investigation, Communication Policy, Documentation Policy, Nurse Review Policy, and Service Plan/Agreements Policy.
- Upon hire, the RNC will provide education to new staff members on the Incident/Accident Reporting Policy, Fall Investigation, Communication Policy, and Documentation Policy.
- RNC will re-educate all staff members on Incident/Accident Reporting Policy, Fall Investigation, Communication Policy and Documentation Policy on 8/31/17.

The program will monitor performance to ensure compliance as follows:

- The Director and RNC will review all Incident Report documentation to ensure that program staff properly complied with Incident/Accident Reporting Policy.
- Director and/or RNC will provide individual education or counseling for staff members who are not compliant with following appropriate policy guidelines.
- Divisional will audit resident records twice per year during onsite visits.

Date deficiencies corrected by: 08/31/2017

A 064 481-67.9(4)g Staffing

Regulatory Insufficiency: Program nurse and staff failed to document observation of a tenant's change in condition, withholding of treatments, and application of treatments that were not prescribed.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #15 was assessed by the physician on 6/29/17 and continues to be followed by the physician as needed. RNC directs/delegates care per physician orders.
- Director and/or RNC will re-educate Staff N, M, B and I on Incident/Accident Reporting Policy, Communication Policy and Documentation Policy on 8/31/17.
- RNC will provide re-delegation to Staff N, M, B and I on Non-Complicated Dressing Changes.

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

- Divisional Director of Resident Services will provide re-education on 8/18/17 to the Director and RNC on the Incident/Accident Reporting Policy, Communication Policy, Documentation Policy, and Nurse Review Policy.
- Divisional Director of Resident Services will provide re-education on 8/18/17 to the RNC on Nurse Delegation, especially Non-Complicated Dressing Changes.
- Upon hire, the RNC will provide education to appropriate staff members on Nurse Delegation, specifically on Non-Complicated Dressing Changes.

- RNC will provide re-delegation to all appropriate staff on Non-Complicated Dressing Changes.

The program will monitor performance to ensure compliance as follows:

- The Director and RNC will review all Incident Report documentation to ensure that program staff properly complied with policy.
- Director and/or RNC will provide individual education or counseling for program staff who are not compliant with following appropriate policy guidelines.
- Divisional will audit resident records twice per year during onsite program visits.

Date deficiencies corrected by: 08/31/2017

A037 481-69.22(2) Evaluation of Tenant

Regulatory Insufficiency: Program failed to complete evaluation of tenants as warranted with a significant change.

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 Tenant #15 on 8/8/17.
- Divisional Director of Resident Service provided RNC re-education on Assessment Policy, Nurse Review Policy, Service Planning and Assessments Policy and Documentation Policy on 8/18/17.

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

- RNC will review Task Sheets, Incident/Accident Reports and Communication Book and observe residents for significant changes and complete assessment updates as needed.

The program will monitor performance to ensure compliance as follows:

- Divisional will audit resident records at least twice per year during onsite program visits and as needed.

Date deficiencies corrected by: 08/31/2017

A047 481-69.23(1)i Criteria for Admission/Retention of Tenants

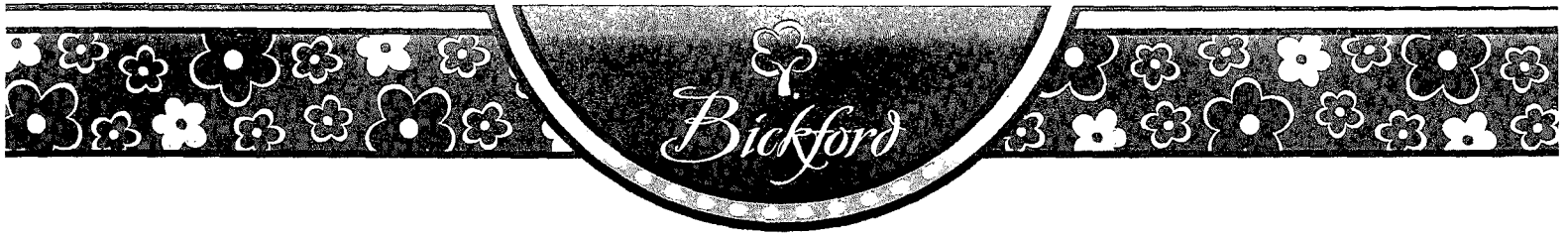
Regulatory Insufficiency: Program failed to discharge tenants who exceeded the criteria for admission and retention for a tenant who required maximal assistance with activities of daily living.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #5 no longer lives at Bickford as of 7/16/17.
- Application of Waiver for Tenant #4 awaiting approval from DIA as of 8/14/17.

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 the criteria for admission and discharge on 8/18/17.
- All staff members will be provided education on residents who are appropriate for ALPs by RNC on 8/31/17.
- RNC will assess all residents prior to move-in and as needed to ensure residents remain appropriate to meet admission and retention criteria.
- Divisional Director of Resident Services will review move-in assessments to determine admission criteria are met.

The program will monitor performance to ensure compliance as follows:

- Divisional will audit resident records at least twice per year during onsite program visits and as needed.

Date deficiencies corrected by: 08/31/2017

A089 481-69.26(4)a Service plans

Regulatory Insufficiency: Tenant service plans were not individualized to identify tenant's needs and preferences for assistance.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #1 no longer lives at Bickford as of 6/14/17.
- Tenants #2, #15 and #16 had evaluations completed and used to update and individualize their Service Plans to appropriately meet the residents' needs and preferences for assistance.
- Divisional Director of Resident Service provided RNC re-education on Assessment Policy, Nurse Review Policy, Service Planning and Assessments Policy and Documentation Policy on 8/18/17.

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 residents for significant changes to initiate evaluations and Service Plan updates to meet resident's needs and their 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 and as needed.

Date deficiencies corrected by: 08/31/2017