

3/10/19 OK  
3/20/19

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0029</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/22/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BICKFORD COTTAGE MARION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 LINDEN DR MARION, IA 52302</b>
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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: 29 Number of tenants with cognitive disorder: 2  Memory Care Unit (if applicable) Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 7  TOTAL Census of Assisted Living Program for People with Dementia : 38  The following regulatory insufficiencies were cited during the investigation into Complaint #79520-C and self-reported incidents #80141-I & 80586-I.	A 000	<p>See attached</p> <div style="border: 1px solid black; border-radius: 50%; width: 150px; height: 100px; margin: 0 auto; display: flex; flex-direction: column; align-items: center; justify-content: center;"> <p>POC</p> <p>2/25/19</p> </div>	
A 003	481-67.2 Program policies and procedures  481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.  This REQUIREMENT is not met as evidenced	A 003		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 003	<p>Continued From page 1</p> <p>by: Based on interview and record review, the facility failed to follow their policy on incident reporting for 3 of 7 tenant files reviewed (Tenant #1, Tenant #5, and Tenant #6).</p> <p>Findings follow:</p> <p>1.a. Record review on 11/14/18 for Tenant #1 revealed an incident report for Tenant #1, dated 7/5/18. According to the incident report, Tenant #1 was found in the hallway yelling for help on 7/5/18 at 12:00 a.m. Tenant #1 was half dressed and bled from the finger on her right hand with blood all over her night clothes. The tenant was unable to tell staff what happened. The Registered Nurse Coordinator (RNC) completed an assessment of Tenant #1 on 7/5/18 at 9:00 a.m. and found a bump on the left side of Tenant #1's head. There was no documentation of an investigation into the injury on the incident report form.</p> <p>b. Record review on 1/15/19 revealed a progress note, dated 8/8/18, documented a conversation between the RNC and Tenant #1's daughter. According to the progress note, staff found bruising on Tenant #1 that morning when they helped her to get dressed. Tenant #1 was unable to provide information regarding how she sustained the injury. The RNC reported to Tenant #1's daughter there were no reports of incidents during the night. Tenant #1's daughter believed her mother may have suffered a fall. Further record review failed to produce an incident report documenting the bruising.</p> <p>c. Record review on 11/14/18 revealed an incident report for Tenant #1, dated 9/8/18. A Certified Nurse's Aide (CNA) found Tenant #1</p>	A 003		

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A 003	<p>Continued From page 2</p> <p>with bruising to her left shoulder, hip and leg. The bruising appeared severe according to the incident report. Tenant #1's left shoulder swelled. Tenant #1 was sent to the hospital via ambulance. A progress note, dated 9/10/18, documented Tenant #1's daughter informed the RNC Tenant #1's arm was broken. There was no documentation of an investigation on the incident report form.</p> <p>Additional record review failed to produce any documentation of investigation into the above incidents.</p> <p>The Program's Incident and Accident Report policy identified incidents included resident falls or injuries. Further record review revealed the Program's policy and procedure regarding accidents and incident reports indicated tenant, staff or visitor incidents or accidents were to be reported and documented immediately after occurrence. Incidents and accidents including: medication errors, staff or visitor injuries and tenant falls and injuries. All accidents or incidents would be documented on the incident report form, the person in charge at the time of the incident or accident would prepare the report and statements from all witnesses would be included.</p> <p>During an interview conducted with the RNC on 1/10/19 at 12:00 PM, she stated she did investigate the above listed incidents by talking to staff about what they witnessed, but did not document the investigation. The RNC reported on 1/15/19 an incident report was not completed for the 8/8/18 incident.</p> <p>2. Record review on 1-17-19 revealed Tenant #5's Progress Notes indicated the following:</p>	A 003		
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A 003	<p>Continued From page 3</p> <p>a. On 7-22-18 it was noted at approximately 6:45 a.m. Tenant #5 exited the building and staff saw him through the memory unit window. Staff went out another door to meet him and Tenant #5 did not want to come inside yet. Staff talked with Tenant #5 and he decided to come inside. Staff escorted Tenant #5 into the building.</p> <p>b. On 12-15-18 it was noted at 7:40 p.m. Tenant #5 exited the building via a side door. Tenant #5 was difficult to redirect with two staff. The Registered Nurse (RN) Coordinator and local police department were notified and Tenant #5 was eventually redirected by staff back into the building.</p> <p>Continued record review revealed no incident reports found related to incidents noted above.</p> <p>3. Record review on 1-17-19 revealed Tenant #6's Progress Notes indicated the following:</p> <p>a. On 11-23-18 it was noted Tenant #6 was at the dining room table and was not wearing pants. Staff attempted several times to redirect her to the restroom. Tenant #6 resisted, swung, punched and attempted to throw a coffee cup at staff. Two staff walked Tenant #6 to restroom and she continued to spit, scratch and attempt to punch and hit.</p> <p>b. On 11-24-18 Tenant #6 slept on the living room sofa. Staff attempted to redirect her to sleep in her bed. Tenant #6 became agitated and attempted to bite, hit and punch staff.</p> <p>c. On 11-24-18 (second shift) Tenant #6 became very agitated and yelled, kicked, slapped,</p>	A 003		
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A 003	<p>Continued From page 4</p> <p>punched and bit staff when cares were attempted.</p> <p>d. On 11-25-18 it was noted staff attempted to assist Tenant #6 from the living room sofa. Tenant #6 was incontinent of urine and refused to be changed. Tenant #6 began to bite, hit and called staff names.</p> <p>e. On 12-1-18 it was noted Tenant #6 refused all attempts to get dressed and to come out to eat. Staff tried four times in the morning and three times at lunch without success to get her dressed and to complete cares. At 1:50 p.m. staff tried to change her clothing and protective undergarment and Tenant #6 became combative and hit at the staff.</p> <p>f. On 12-11-18 it was noted while attempting to get Tenant #6 dressed a staff was scratched on the arm and another staff was kicked. Tenant #6 also tried to bite staff.</p> <p>Continued record review revealed no incident reports were found related to incidents noted above with Tenant #6.</p> <p>Further record review revealed the Program's policy and procedure regarding accidents and incident reports indicated tenant, staff or visitor incidents or accidents were to be reported and documented immediately after occurrence. Incidents and accidents including: medication errors, staff or visitor injuries and tenant falls and injuries. All accidents or incidents would be documented on the incident report form, the person in charge at the time of the incident or accident would prepare the report and statements from all witnesses would be included.</p>	A 003		

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A 003	Continued From page 5  When interviewed on 1-22-19 at 11:39 a.m. the Director revealed there were no additional incident reports for the time period requested for Tenant #5 and Tenant #6.	A 003		
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 observation, interview and record review the Program failed to provide a sufficient number of trained staff to fully meet a tenant's identified needs. This pertained to 1 of 1 tenant (Tenant #5) reviewed as a result of program self-reported incident #80586-I. Findings follow:  Record review on 1-17-19 of Tenant #5's file revealed diagnoses included traumatic brain injury (TBI), mild cognitive impairment and post-traumatic stress disorder. Tenant #5 scored a 28/30 on the Mini Mental Status Examination, dated 10-26-18. The service assessment, dated 10-26-18, reflected Tenant #5 had a large appetite and the majority of the time he would exit seek because he would be offered a snack if he stop attempting to leave. Tenant #5 also displayed exit seeking behavior because he was looking for his truck or when he thought he had guard duty. If Tenant #5 left the building staff would walk beside him and ask what he was looking for. The service assessment indicated	A 055		

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A 055	<p>Continued From page 6</p> <p>Tenant #5 wore an electronic wandering monitoring watch due to exit seeking behaviors.</p> <p>Continued record review of an incident report, dated 12-9-18, revealed Tenant #5 was asked to go to bed at approximately 11:30 p.m. Two staff started to complete night checks when the pager sounded at 11:35 p.m. Staff responded to the front door and the front door alarm sounded. Tenant #5 had walked out of the front door. Two staff responded and asked Tenant #5 to come inside. He refused and said he had guard duty. Staff in the memory care unit was alerted to check the side doors and Tenant #5 was not within sight. One staff came inside to call 911, the police responded and began a search. Tenant #5 was found approximately one hour later and was returned safely. Tenant #5 was assessed upon return and vital signs were as follows: blood pressure 136/80, temperature was 97.4 degrees Fahrenheit (F), pulse 86 and respirations 20.</p> <p>When interviewed on 1-17-19 at 2:23 p.m. Staff B reported it was a normal night. Staff completed rounds when they heard the pager. The pager indicated Tenant #5 exited the front door. Staff responded and found Tenant #5 on the side of the building. Staff B went inside to call 911 and Staff C stayed with him outside. Staff C returned inside and said he would not stop. Staff called back to the memory care unit and staff there could not see him. The police showed up and started looking for Tenant #5. The Director arrived and started to search for Tenant #5. The Registered Nurse Coordinator (RNC) was also notified. The search lasted about an hour and police returned with Tenant #5. He was found seven blocks from the Program. Tenant #5 did not sustain any injuries and wore shoes, pants</p>	A 055		
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A 055	<p>Continued From page 7</p> <p>and a jacket. The weather was cold and there was no snow on the ground. Tenant #5 wore an electronic wandering monitoring watch and he ambulated independently. The alarms functioned appropriately and staff responded in approximately one minute.</p> <p>When interviewed on 1-17-19 at 3:00 p.m. Staff C reported Tenant #5 was focused on going to do guard duty the night of the incident and Staff B thought he was going to leave. Staff was completing rounds, the door alarm and pager sounded and staff responded. Staff found Tenant #5 had exited the front door and was on the southwest side of the building. Staff tried to redirect him without success. Tenant #5 reported he had guard duty and was not returning inside. Staff B went inside to call the police. Staff C stayed outside after Staff B went inside but when Staff C knew Tenant #5 was not coming inside she went inside to call staff in the memory care unit to open up the side doors (staff had their phones). Staff in the memory care unit went to the opposite door. Staff went outside and could not find him. Police arrived and searched for Tenant #5. The Director and RNC were contacted. The Director arrived at the building and searched for Tenant #5. He was found approximately six blocks from the Program. Tenant #5 was returned to the building in approximately one hour and did not have any injuries.</p> <p>When interviewed on 1-17-19 at 12:02 p.m. the RNC revealed she was called and told Tenant #5 eloped and staff was not able to find him. Police and the Director searched for him. She did not have any other direct involvement with the incident. The Director sent a text message to her later to let her know they had found Tenant #5 in</p>	A 055		
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A 055	<p>Continued From page 8</p> <p>a residential area. Tenant #5 had a TBI and at times thought he was on guard duty. Staff tried to redirect him with snacks and soda when he displayed exit seeking behavior.</p> <p>When interviewed on 1-22-19 at 10:13 a.m. the Director said staff called her to report Tenant #5 left the building and police were looking for him. Staff reported the front door alarm sounded (staff responded) and Tenant #5 would not come back inside. Staff went inside and called 911. The Director arrived at the building, took a flashlight and began looking for him. Tenant #5 was found by police and returned to the building. Tenant #5's hands and ears were warm to the touch and he seemed to be at his baseline. Tenant #5 did not sustain any injuries. Tenant #5 wore a heavy sweatshirt with pockets, long pants, shoes and socks. Tenant #5 was found approximately four blocks from the Program. The door alarm and electronic wandering monitoring watch functioned when Tenant #5 exited the building. When the Director questioned why Staff C came into the building she said she wanted to check on the status. Staff C reported to the Director that she had her portable phone. Redirection was provided individually to the staff involved in the incident regarding not leaving a tenant unattended after exiting the building and to carry portable phones. A staff in-service was also held to re-educate staff. Staff did not follow the policy and procedure related to the incident with Tenant #5.</p> <p>Record review revealed Counseling Forms for Staff B and Staff C re-education was provided related to the incident with Tenant #5. It identified in a recent elopement a tenant was left unattended after exiting the building. It was expected that staff stay with the tenant and</p>	A 055		
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A 055	<p>Continued From page 9</p> <p>communicate to other staff via portable phones. The forms also indicated further education would be provided at an in-service. In-service documentation was provided including a list of attendees.</p> <p>Continued record review of the electronic wandering monitoring system records and door alarm records revealed on 12-9-18 at 11:35 p.m. the front door was opened and reflected an alert for Tenant #5's electronic wandering monitoring watch at the front door. It also reflected the front door closed. Records reflected on 12-10-18 at 12:41 a.m. the front door alarm was reset and it reflected Tenant #5's electronic wandering device alerted. Based on records Tenant #5 was gone from the building for one hour and five minutes.</p> <p>Weather conditions at the Monticello Regional Airport on 12-9-18 at 11:30 p.m. included the following: temperature was 16 degrees, the wind was calm, relative humidity was 92%, and there was no wind chill and no precipitation.</p> <p>The exact location Tenant #5 was found could not be provided as police found the tenant. Staff interviews estimated four to seven blocks. The general path described in the Director's interview was driven by car and distance traveled was 0.4 of a mile. The exact path Tenant #5 traveled could not be determined; however, possible terrain Tenant #5 encountered included: parking lots, grass areas, sidewalks, residential properties and city streets.</p> <p>In summary, Tenant #5 had a history of exit seeking behavior, wore an electronic wandering monitoring watch and staff was instructed to walk with him if he exited the building. Tenant #5 left the building on third shift and staff was alerted he</p>	A 055		
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A 055	Continued From page 10  exited through the front door. Staff responded and were unable to redirect Tenant #5 back into the building. One staff went inside the building to call 911 and then the other staff returned inside, leaving Tenant #5 unattended after he exited the building. Tenant #5 was gone for approximately one hour and returned after a search that involved police assistance.	A 055		
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, 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.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to maintain a written communication log for a period of not less than	A 064		

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A 064	Continued From page 11 three years. Findings follow:  Record review on 11/14/18 revealed the Program provided the monitor with one week of documentation from the communication log.  When interviewed on 11/14/18 at 3:35 PM the Director reported the Program kept record of the written communication log for only one week.	A 064		
A 083	481-69.26(1) Service Plans  481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to make changes to a service plan following a significant change for 1 of 7 tenant files reviewed (Tenant #1). Findings follow:  Record review on 11/14/18 revealed Progress Notes for Tenant #1, dated 8/22/18, documented Tenant #1 was very irritated, yelled at staff and tried to hit them with her cane. The Director and Registered Nurse Coordinator (RNC) met with Tenant #1's daughter regarding the tenant's	A 083		

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A 083	<p>Continued From page 12</p> <p>behaviors and need to be assessed in the Emergency Room. Tenant #1's daughter took her to the emergency room for an evaluation at the hospital.</p> <p>An additional progress note documented Tenant #1's daughter communicated on 8/23/18 Tenant #1 had a bladder infection and had been admitted to the hospital. The program was informed by the social worker at the hospital on 8/23/18. Tenant #1 had been started on antipsychotic, antidepressant and antibiotic medication for treatment of her condition.</p> <p>Progress Notes further documented the RNC assessed Tenant #1 while in the hospital on 8/24/18. The RN Coordinator documented in the Progress Notes she discussed plan for Res (Tenant #1) to return to Bickford with plan to transition to Mary B's (dedicated dementia unit) when available.</p> <p>Additional record review revealed Tenant #1's service plan, dated 8/14/18, noted completion due to change of condition at that time. The service plan noted Tenant #1 had chronic kidney disease, as well as only one kidney; however, the service plan did not reference any concerns with urinary tract infections or bladder infections. Additional updates to the service plan could not be located.</p> <p>When interviewed on 11/15/18 at 9:05 a.m., the RNC stated she met with Tenant #1 and her daughter at the hospital on 8/24/18. They discussed suggestions for the staff on how to better care for Tenant #1 upon her return to the Program. They also discussed the possibility of Tenant #1 moving to Mary B's when an apartment was available. The RN Coordinator stated she</p>	A 083		
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A 083	Continued From page 13  did not update Tenant #1's service plan following the hospitalization. The RNC reported she had been told in the past Tenant #1 had urinary tract infections due to her Chronic Kidney Disease. The RNC confirmed this was not reflected in the service plan.	A 083		
A 089	481-69.26(4)a Service Plans  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  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to develop service plans to reflect the identified needs of the tenants. This pertained to 3 of 7 tenants reviewed (Tenants #5, #6 and #7). Findings follow:  1. Record review on 1-17-19 of Tenant #5's file revealed a diagnosis included leg edema. A Physician Visits form, dated 11-6-18, reflected Tenant #5 had a 14 pound weight gain noted in a month. Tenant #5 had a decreased appetite, slept more during the day and fell asleep at the table. Edema was noted to the bilateral legs and Tenant #5 had nocturia. An order was received to increase the dose of Lasix to 40 milligrams, two tablets daily, for seven days.  Continued record review revealed the November and December 2018 medication administration	A 089		

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A 089	<p>Continued From page 14</p> <p>records (MARs) reflected to check Tenant #5's weight weekly and to notify the physician if Tenant #5 gained more than five pounds in a week. The start date on the MAR was 11-16-18. Staff initialed and recorded Tenant #5's weight on 11-21-18. The next recorded weight was on 12-5-18; which was greater than one week.</p> <p>Further record review revealed Tenant #5's service plan dated 10-26-18 did not reflect the weight gain and staff assistance with weekly weights.</p> <p>2. Record review on 1-17-19 of Tenant #6's file revealed the service plan dated 1-4-19 reflected staff would provide escorts to and from all meals. Tenant #6 had a walker for balance.</p> <p>Observation on 1-17-19 at approximately 11:55 a.m./12:00 p.m. revealed Tenant #6 was seated in a wheelchair at the dining room table.</p> <p>When interviewed on 1-17-19 at 12:02 p.m. the Registered Nurse (RN) Coordinator reported Tenant #6 had a wheelchair for mobility used daily and also a new walker. Tenant #6 required assistance of two staff with transfers approximately 50% of the time.</p> <p>Continued record review revealed Tenant #6's service plan, dated 1-4-19, failed to reflect the use of a wheelchair or the need for a two person transfer at times for Tenant #6.</p> <p>3. Record review on 1-17-19 revealed Tenant #7's Physician's Orders included Ensure: one can twice daily, with meals at 12:00 p.m. and 5:00 p.m., ordered 7-3-18. The December 2018</p>	A 089		
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A 089	<p>Continued From page 15</p> <p>MARs reflected staff assisted Tenant #7 with the Ensure, one can twice daily with meals at 12:00 p.m. and 5:00 p.m.</p> <p>Continued record review revealed Tenant #7's service plan dated 11-30-18 failed to reflect the nutritional supplement or staff assistance with the physician ordered task.</p> <p>4. When interviewed on 1-17-19 at 12:02 p.m. the RN Coordinator confirmed all service plan documents requested for the tenants noted above were provided.</p>	A 089		
A 154	<p>481-69.35(1)b Structural Requirements</p> <p>481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure a well-maintained building, as evidence by the failure of a secondary alarm system to monitor wandering activity. This affected 1 of 1 tenant identified as a result of program self-reported incident #80141-I (Tenant #6). Finding follows:</p> <p>Record review on 1-17-19 of Tenant #6's file revealed diagnoses included dementia with psychosis, major neurocognitive disorder and late onset Alzheimer's disease without behavioral disturbance. Tenant #6 was admitted to the Program 11-11-18. Tenant #6 scored a 5/30 on</p>	A 154		

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A 154	<p>Continued From page 16</p> <p>the Mini Mental Status Examination, dated 11-6-18. On 1-4-19 Tenant #6 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. The service plan dated 11-6-18 indicated Tenant #6 wore an electronic wandering monitoring watch due to her cognition and exit seeking behavior.</p> <p>Continued record review revealed an incident report dated 11-15-18 at 8:30 p.m., documented the fire alarm went off at 8:30 p.m. Staff began evacuating tenants to a safe area. The Director and Registered Nurse Coordinator (RNC) were notified. Staff completed a head count and discovered Tenant #6 unaccounted for. A search began inside and outside the building. Tenant #6 was found near the entrance at a neighboring grocery store. Tenant #6 had her walker with her and did not wear a coat. Tenant #6 said, "I pulled that thing so I could get out!" An ambulance arrived and Tenant #6 was taken to the hospital.</p> <p>Weather conditions at the Eastern Iowa Airport on 11-15-18 at 8:30 p.m. included the following: temperature was 34 degrees, winds were from the south-southwest at 14 miles per hour, the wind chill was 23 degrees, relative humidity was 64% and skies were mostly cloudy with no precipitation.</p> <p>Observation on 1-17-19 and 1-22-19 revealed the approximate distance Tenant #6 traveled was 0.1 of a mile. The exact path Tenant #6 traveled could not be determined; however, the possible terrain Tenant #6 encountered included: parking lots, grass areas, sidewalks, and city streets.</p> <p>When interviewed on 1-17-19 at 11:09 a.m. Staff A revealed the incident occurred on second shift; everyone was in their apartments and the fire</p>	A 154		
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A 154	<p>Continued From page 17</p> <p>alarm went off. Staff evacuated tenants from their apartments, but Tenant #6 was not in her apartment. The Director and RNC were notified and the RNC arrived to the building quickly. The fire department arrived and noted a side exit door was cracked. The RNC and firefighters found Tenant #6 outside of a neighboring grocery store. Tenant #6 did not have a coat or hat, but wore pants, shoes, shirt and a sweater. Tenant #6 told emergency medical services (EMS) she pulled the fire alarm. Tenant #6 wore an electronic wandering monitoring watch; however, nothing sounded on the pager and no door alarms were heard. Tenant #6 did not have any injuries, but went to the emergency room (ER) for evaluation. Staff A estimated Tenant #6 was gone approximately 10 to 15 minutes.</p> <p>When interviewed on 1-17-19 at 3:39 p.m. Staff D reported the fire alarms went off at 8:30 p.m. Staff evacuated the tenants from their apartments. The fire department was there and the RNC arrived. A head count was started and determined Tenant #6 was missing. The fire department noticed a door propped open. Staff stayed at the Program and the fire department searched and found her at a neighboring grocery store. Tenant #6 did not have any injuries that Staff D was aware of and she was taken to the hospital. Staff D estimated Tenant #6 was gone less than 10 to 15 minutes.</p> <p>When interviewed on 1-17-19 at 3:22 p.m. Staff E said she administered medications when the fire alarm sounded. The RNC was notified. Tenants were checked and Tenant #6 could not be found. The fire department arrived and realized a door was open. The RNC was there and they searched for her. They found Tenant #6 outside, but Staff E did not know exactly where she was</p>	A 154		

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A 154	<p>Continued From page 18</p> <p>located. Tenant #6 was taken to the hospital and had no injuries. Prior to that incident Staff E administered Tenant #6's bedtime medications. Staff E reported nothing came across the pager regarding door alarms or the electronic wandering monitoring system.</p> <p>When interviewed on 1-17-19 at 12:02 p.m. the RNC recalled staff called to report the fire alarm went off and staff began evacuating tenants. The fire department responded immediately and determined the pull station by a side door had been pulled. Staff was instructed to complete a head count and determined Tenant #6 was unaccounted for. The fire department reported a door near the pulled fire alarm station was opened. The RNC went outside to search for Tenant #6. A neighbor reported they saw a woman with a walker. Tenant #6 was found at the exit door of a neighboring grocery store (the store was open). The weather was cold and there was no snow. Tenant #6 wore a long sleeved shirt, pants, shoes and socks, but did not wear a coat. Tenant #6 did not have any injuries and she was taken into the grocery store to warm up. Tenant #6 said she pulled the fire alarm. EMS arrived and took her vital signs, which were within normal limits. Tenant #6 was taken to the ER for evaluation. Tenant #6 refused to leave the hospital and they kept her over the weekend. The time between when the fire alarm sounded and when Tenant #6 was found was approximately seven to eight minutes. Staff was not made aware the door was opened and were not alerted by electronic wandering monitoring system.</p> <p>When interviewed on 1-22-19 at 9:43 a.m. the Maintenance Staff revealed when the fire alarm was activated all exterior doors were unlocked. After Tenant #6's elopement, he was made aware</p>	A 154		
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A 154	<p>Continued From page 19</p> <p>a tenant pulled the fire alarm and the electronic wandering monitoring system did not alert staff. It was determined one of the wall units of the electronic wandering monitoring system was bad and it was replaced the next day. Maintenance staff reported the electronic wandering monitoring system was checked monthly and there was no prior indication it was not working. Record review of the electronic wandering monitoring system records and door alarm records revealed on 11-15-18 at 8:28 p.m. a side door was opened and at 8:29 p.m. it was closed. There were no records of an alert for Tenant #6's electronic wandering monitoring watch at the time the door was opened and closed.</p> <p>Continued record review revealed the Program's policy and procedure regarding tenant monitoring system use and maintenance indicated the system would be inspected and maintained to ensure appropriate functioning at all times. The monitoring system would be inspected monthly to ensure it was functioning appropriately. The Resident Monitoring System Testing Procedure Checklist would be used to complete the inspection. The completed checklists would be kept for two years. Each building would maintain spare equipment including a spare watch.</p> <p>Monthly checks of the electronic wandering monitoring system were requested; however, checks were not documented or available for review. A test of the system was completed on 1-22-19, but a spare watch was not available to check the system. When interviewed on 1-22-19 at 10:11 a.m. the Director confirmed the monthly checks for the electronic wandering monitoring system were not documented.</p>	A 154		

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A 154	Continued From page 20  When interviewed on 1-22-19 at 10:13 a.m. the Director reported staff either did not receive a page for the electronic wandering monitoring system or received the page in a delayed manner when Tenant #6 eloped. There was a defect in the electronic wandering monitoring system and it was repaired the next day. After Tenant #6's incident, covers were placed on the fire pull stations that were audible.	A 154		

✓ 3/20/19  
OK 3/20/19

**Plan of Correction  
Marion Bickford Cottage**

**A 003—481-67.2 Program policies and procedures**

**Regulatory Insufficiency: The Program failed to follow policy on incident reporting.**

**Plan of Correction:**

**The insufficiencies will be corrected as follows:**

- Tenant #1 no longer resides at Bickford as of 09/08/18.
- RN performed a Nursing Assessment, Cognitive Assessment, Service Assessment and a Service Plan update for Tenant #5 on 2/4/19.
- RN performed a Nursing Assessment, Cognitive Assessment, Service Assessment and a Service Plan update for Resident #6 on 2/22/19.

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

- Divisional Director of Resident Services provided re-education on 2/19/19 to the Director and Backup RNC on the Incident/Accident Report Policy and provided education to the new RNC on 2/25/19.
- The Director, RNC or back up RNC will provide education to new staff members, upon hire, on the Incident/Accident Report Policy.
- Director or back up RNC will re-educate all staff members on Incident/Accident Report Policy on 2/20/19. Those staff who are not in attendance shall be provided 1:1 education by Director or designee.

**The program will monitor performance to ensure compliance as follows:**

- The Director, RNC back up or RNC will review all Incident Report documentation to ensure that program staff properly complied with Incident/Accident Report Policy.
- Director and/or RNC(RNC Back up) 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 to ensure that incidents have been properly documented.

**Date deficiencies corrected by: 2/25/19**

**A 055—481-67.9(1) Staffing:**

**Regulatory Insufficiency: The Program failed to provide sufficient number of trained staff to fully meet a tenant's identified needs.**

**Plan of Correction:**

**The insufficiencies will be corrected as follows:**

- RN performed a Nursing Assessment, Cognitive Assessment, Service Assessment and a Service Plan update for Tenant #5 on 2/4/19.
- Director provided re-education on 12/12/18 to Staff B on Unwitnessed Door Alarm Policy and Missing Resident Policy.

- Director provided re-education on 12/10/18 to Staff C on Unwitnessed Door Alarm Policy and Missing Resident Policy.

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

- Divisional Director of Resident Services provided re-education on 2/19/19 to the Director and Back up RNC on the Unwitnessed Door Alarm Policy and Missing Resident Policy and provided education to the new RNC on 2/25/19.
- The Director, RNC or back up RNC will provide education to new staff members, upon hire, on the Unwitnessed Door Alarm Policy and Missing Resident Policy.
- Director or back up RNC will re-educate all staff members on Unwitnessed Door Alarm Policy and Missing Resident on 2/20/19. Those staff who are not in attendance shall be provided 1:1 education by Director or designee

**The program will monitor performance to ensure compliance as follows:**

- Divisional Director will audit employee files through quality audits annually to ensure compliance with training and review of Missing Resident/Unwitnessed Door Alarm Drills.

**Date deficiencies corrected by:** 2/25/19

**A 064 481-67.9(4)g Staffing:**

**Regulatory Insufficiency:** The program failed to maintain a written communication log for a period of not less than three years.

**Plan of Correction:**

**The insufficiencies will be corrected as follows:**

- Divisional Director of Resident Services provided education on 2/19/19 to the Director and Back up RNC on maintaining written communication logs for 3 years and provided education to the new RNC on 2/25/19.

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

- Director will maintain at least 3 years of written communication logs.

**The program will monitor performance to ensure compliance as follows:**

- Divisional will audit communication log files annually during onsite visits.

**Date deficiencies corrected by:** 2/25/19

**A 083 481-69.26(1) Service Plans:**

**Regulatory Insufficiency:** The program failed to make changes to a service plan following a significant change.

**Plan of Correction:**

**The insufficiencies will be corrected as follows:**

- Tenant #1 was discharged from the program on 9/8/18.
- Divisional Director of Resident Services provided re-education on 2/19/19 to the Director and Back up RNC on Service Plan Policy and provided education to the new RNC on 2/25/19.

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

- RNC/Back up RNC will review Incident/Accident Reports, Communication Book and observe residents for significant changes that trigger the initiation of new 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 visits to determine Service Plans meet the resident's identified needs.

**Date deficiencies corrected by:** 2/25/19

#### **A 089—481-69.26(4)a Service Plans**

**Regulatory Insufficiency:** The program failed to develop service plans to reflect the identified needs of tenants.

#### **Plan of Correction:**

**The insufficiencies will be corrected as follows:**

- Tenant #5 had evaluations completed and used to update and individualize their Service Plan to appropriately meet the resident's needs on 2-4-19.
- Tenant #6 had evaluations completed and used to update and individualize their Service Plan to appropriately meet the resident's needs on 2/22/19.
- Tenant #7 had evaluations completed and used to update and individualize their Service Plan to appropriately meet the resident's needs on 2/18/19.
- Divisional Director of Resident Services provided re-education on 2/19/19 to the Director and Back up RNC on Service Plan Policy and provided education to the new RNC on 2/25/19.

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

- RNC/Back up RNC will review Incident/Accident Reports, Communication Book, and observe residents for changes and initiation of new evaluations and Service Plan updates in order to meet the resident's identified needs.

**The program will monitor performance to ensure compliance as follows:**

- Divisional will audit resident records at least twice per year during onsite visits to determine Service Plans meet the resident's identified needs.

**Date deficiencies corrected by:** 2/25/19

#### **A 154—481-69.35(1)b Structural Requirements:**

**Regulatory Insufficiency:** The program failed to ensure a well-maintained building, as evidenced by the failure of a secondary alarm system to monitor wandering activity.

#### **Plan of Correction:**

**The insufficiencies will be corrected as follows:**

- Tenant #6 had evaluations completed and used to update and individualize their Service Plan to appropriately meet the resident's needs on 2/22/19.
- Divisional Director of Resident Services provided re-education on 2/19/19 to the Director and Back up RNC on the Home Free Policy and provided education to the new RNC on 2/25/19.
- Director provided re-education with the Maintenance Director on 1/31/18 on the Home Free Policy.
- Wall Electronic wandering monitoring system was repaired on 11/16/18.
- Clear audible covers were placed over fire pull stations following the event.

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

- Maintenance Director or Director will inspect monitoring system monthly to ensure proper functioning and document findings. These records will be maintained for two years.

**The program will monitor performance to ensure compliance as follows:**

- Divisional Director will audit Home Free inspection documentation twice per year during quality audits.

**Date deficiencies corrected by: 2/25/19**