IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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RODNEY A. ROBERTS, DIRECTOR

January 8, 2015

Ms. Megan Johnson, Director
Bickford Cottage of Muscatine
2807 Cedar Street
Muscatine, IA 52761

RE: Final Recertification Monitoring Evaluation Report – Bickford Cottage of Muscatine, Muscatine, IA

Dear Ms. Johnson:

Enclosed is the **Final Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following a survey by DIA on **December 22, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Medications, Record Checks, Transportation and Structural Requirements.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Also enclosed you will find the Assisted Living Program Certificate **S0009** with effective dates of **October 1, 2014** through **September 30, 2016**.

If you have any questions in regard to this report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0009	A. BUILDING _____ B. WING _____	12/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE MUSCATINE	2807 CEDAR ST MUSCATINE, IA 52761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-67 Initial Comments 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. Dementia-Specific Program by Definition Number of tenants without cognitive disorder: 20 Number of tenants with cognitive disorder: 6 Total Population of Program at time of on-site. 26 Dementia-Specific Program by DedicationNumber of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 7 Total Population of Program at time of on-site: 7 TOTAL census of Assisted Living Program: 33 The following regulatory insufficiencies were cited during the monitoring visit conducted to determine compliance with certification for an Assisted Living Program	A 000		
A 036	481-67.5(6)a Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: a. The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67.9(4) or a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted	A 036		

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A 036	Continued From page 1 by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: Based on observation of a medication pass and staff interview, medications were administered using labeled food products that exceeded the appropriate time frame for use. Per observation of a medication administration pass, Tenants #4 and #5 were given medications with pudding or nectar thickened water that exceeded the three day proper use expectation as indicated by the Dietary Manager. On 12-22-14 from 11:35 a.m. to 12:20 p.m. the monitor observed Staff A during a medication administrtion pass. Tenant #4 received his/her medication mixed in pudding. The pudding was in a plastic multi-serving container retrieved from a refrigerator in the medication room and dated 12-16-14. Tenant #5 received his/her medication with a nectar thickened water. The thickened water was in a plastic multi-serving container retrieved from a refrigerator in the medication room and dated 12-19-14. On 12-22-14 at 2:00 p.m. the Dietary Manager was interviewed and asked what the expectation was regarding the length of time opened and labeled food could be served. She stated the food rules indicated three days and the example she always used was if a container was opened on July 1st, then the food needed to be discarded on July 3rd. She stated they did not have a policy that specifically referenced this but the state approved food course rules dictated the three day	A 036		

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A 036	Continued From page 2 policy.	A 036		
A 118	481-67.19(3) Record Checks 481-67 19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on review of staff files and staff interview, further research as required for a criminal history check and criminal, dependent adult abuse and child abuse record checks were not completed prior to employing two staff. Per review of staff files and interview with the Divisional Director of Operations (DDO) Staff B was hired without completion of further research as required for a criminal history and Staff C was hired without completion of criminal, dependent adult abuse and child abuse record checks. Staff B's file was reviewed and revealed a background check completed on 6-17-13 required further research for the Criminal History Background Check. Staff B was hired on 6-27-13 without any evidence of the additional research being completed. Staff C's file was reviewed. Staff C was hired on	A 118		

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A 118	Continued From page 3 8-2-13 and criminal, dependent adult abuse and child abuse record checks were not completed prior to employment. The DDO completed the criminal, dependent adult abuse and child abuse record checks during the on-site visit on 12-22-14 The DDO was interviewed and stated when she was pulling the documents for the monitors' review, she discovered Staff B's further research for a criminal history had not been completed and Staff C was hired without completion of criminal, dependent adult abuse and child abuse record checks.	A 118		
A 148	481-69.33(7) Transportation 481-69.33(231C) Transportation. When transportation services are provided directly or under contract with the program: 69.33(7) Each vehicle shall have a first-aid kit, fire extinguisher, safety triangles and a device for two-way communication. This REQUIREMENT is not met as evidenced by: Based on monitor review of transportation equipment the bag used by Program staff did not include a fire extinguisher. Per the monitor observation, a fire extinguisher was not available for use during transportation of tenants. The Divisional Director of Operations was interviewed and stated the Program had two staff who transported tenants in their personal cars. The monitor reviewed the equipent located in a bag taken by staff when they transported tenants. The bag included a first-aid kit and a safety	A 148		

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A 148	Continued From page 4 triangle. The bag did not include a fire extinguisher.	A 148		
A 154	481-69.35(1)b Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by: Based on monitor oberservations and interview, the Program did not maintain a safe environment. Per monitor observation and interview, the beauty shop was left unlocked and open with accessibility to chemicals, scissors and box cutters. On 12-22-14 at 12:40 p.m. the monitor observed the beauty shop door open without any staff present. The monitor observed a pair of scissors in a vanity drawer; three pairs of scissors and a razor in a rolling cart and pliers, screwdriver, putty knife and box cutters in an unlocked large rubber cabinet. The wooden built in cabinets with four doors were all unlocked with the key in the lock of the top left door. Multiple hair care products, boxes of perm solution, clipper oil, Dissolve cleaner, wax warmer, Lysol cleaner and other cleaners were observed in the cabinets. Many items included a warning that stated harmful if swallowed and to keep out of reach of children. All items were accessible to anyone who might enter the unlocked shop. On 12-22-14 at 1:00 p.m. the monitor observed the beauty shop door closed. Upon entering, the	A 154		

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A 154	Continued From page 5 beautician was observed providing hair care to a tenant. When informed that the monitor had been in the beauty shop at 12 40 p.m., the beautician stated she had left the building to go home for lunch	A 154		

Plan of Correction
Muscatine Bickford

A. Medications (A036)

Regulatory Insufficiency: Medications were administered using labeled food products that exceeded the appropriate time frame for use.

Plan of Correction
The insufficiency will be corrected as follows:

- All medications, that are administered utilizing food products, will be administered with food used within the dated time frame for use.
- Our pharmacy will supply labels for food products used, such as pudding, applesauce and thickened liquids, that will be filled out and state the discard date.

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

- The food products in the Med Room were added to the nightly cleaning checklist that staff will initial to sign off when completed, ensuring that there is no expired product.
- Food labels are currently in use; training started immediately after State exited on 12-22-14, and we have scheduled an in-service meeting to ensure everyone is trained on the new label process and cleaning checklist on 01-29-15.

The program will monitor performance to ensure permanent solutions in the following manner:

- Director will ensure that checklists are completed on a weekly basis.

Date deficiencies corrected by: 01-29-15

B. Record Check (A118)

Regulatory Insufficiency: Further research, as required for a criminal history check and criminal, dependent adult abuse and child abuse records, was not completed prior to employing two staff.

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

- Criminal history background checks, adult abuse and child abuse checks on Staff B and Staff C were completed and both are cleared to work with no records found or further research needed.
- Bickford will complete the required background checks prior to employing staff.

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

- Assistant Director will ensure that the hiring checklist is completed and that all documentation is in personnel file at the time of hire.

The Program will monitor performance to ensure compliance as follows:

- Divisional Director of Operations will complete an audit of personnel files at least on an annual basis

Date deficiencies corrected by: Completed on 12-23-14

C. Transportation (A148)

Regulatory Insufficiency: **Transportation equipment bag did not include a fire extinguisher.**

Plan of Correction

The insufficiency will be corrected as follows:

- Bickford will supply the necessary equipment in a vehicle utilized to transport residents.
- Director will be responsible to ensure that all necessary equipment is available for the transportation bag.

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

- Each staff member, prior to transporting a resident, will inspect the equipment bag by reviewing the contents against the checklist for the bag.
- The training regarding the contents of safety bag and the checklist will be at the 01 -29-15 in-service meeting

The program will monitor performance to ensure permanent solutions in the following manner:

- The Director will be responsible to ensure the bag is audited quarterly.

Date deficiencies corrected by: Bag complete as of 1-13-15. Staff trained as of 01-29-15.

D. Structural requirements (A154)

Regulatory Insufficiency: **The Program did not maintain a safe environment.**

Plan of Correction

The insufficiency will be corrected as follows:

- Bickford will ensure that items with warnings are kept in locked storage.
- All cupboards, drawers and doors are locked in the Salon at this time. The chemicals, box cutters and scissors will be kept within locked cabinets at all times.

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

- The Beautician was retrained on the expectations of making sure, when she is not in the salon, that all items are locked up, on 01-08-15. She is to lock all doors, cabinets and drawers as she exits the Salon at any time.

The program will monitor performance to ensure permanent solutions in the following manner:

- Director will ensure that the necessary items are kept under lock.
- Dementia training will also be completed with the Beautician annually.
- The Director will go over safety rules and policies with the Beautician.

Date deficiencies corrected by: Dementia training will be completed by the Beautician by 02-13-15.