IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
51666-I
50744-I

February 10, 2015

Ms. Laura Brock, Director
Bickford Cottage Davenport
4040 E. 55th Street
Davenport, IA 52806

RE: Final Complaint/Incident Investigation Report, Bickford Cottage Davenport, Davenport, Iowa

Dear Ms. Brock:

Enclosed is the **Final Complaint/Incident Investigation 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 an investigation by DIA on **January 28 and 29, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Program Policies and Procedures and Staffing.

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.

If you have any questions in regard to the enclosed 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
	S0054	A. BUILDING: _____ B. WING _____	C 01/29/2015

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BICKFORD COTTAGE DAVENPORT	4040 E 55TH ST DAVENPORT, IA 52806

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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. General Population Program Number of tenants without cognitive disorder: 24 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 28 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 6 Total Population of Program at time of on-site 6 TOTAL census of Assisted Living Program: 34 Incidents #50744-I and #51666-I were investigated. Incident #50744-I pertained to an incident regarding Tenant #1 and there were regulatory insufficiencies identified. Incident #51666-I pertained to two incidents, one regarding Tenant #2 and one regarding Tenant #3. There were no regulatory insufficiencies identified regarding incident #51666-I involving Tenant #2. There were regulatory insufficiencies identified regarding incident #51666-I involving Tenant #3.	A 000		
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	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	Continued From page 1 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 by: Based on review of tenant files, staff interviews, staff statements and review of Program documents the Program failed to follow Program policies and procedures regarding a narcotic medication count, completion of an incident report and nurse notification of an incident. A count of narcotic medication was not completed per policy on a date when Tenant #1's narcotic medication was missing, an incident report was not completed per policy regarding Tenant #1's missing narcotic medication and the Nurse was not notified of an incident and a significant change involving Tenant #3 in accordance with the policy. 1. Tenant #1, a 79 year old, was admitted on 10-12-09 and diagnoses included: cerebral vascular accident/transient ischemic attack, advanced laryngeal cancer, urinary tract infection, deep vein thrombosis, chronic obstructive pulmonary disease and bi-polar disorder. Tenant #1 was discharged. According to the service plan dated 11-13-14, Tenant #1 had medications administered by the Program. Tenant #1 had an order for Hydrocodone/APAP 5-325 milligrams one to two tablets by mouth every six hours as needed for pain, according to Physician Orders. 2. According the Director's statement, Tenant #1 had eight tablets of missing Hydrocodone/APAP. The medication was locked in the medication	A 003		

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A 003	Continued From page 2	A 003		

cart, which was kept in the central medication room. The medication was kept under double lock, separate from other medications and with a separate key. The medication room key and narcotic box keys were kept with the individual passing medications and the door was shut when not in use. The door had an automatic lock. On 11-3-14 Staff A had access to the medication room and medication cart until 3:00 p.m. when Staff B took over the keys to the medication room and cart. On the day of the missing medications it was believed Staff A and Staff B got rushed and did not do their due diligence in accurately accounting for the narcotic medications It was the belief during the shift change between Staff A and Staff B the medication was pulled out of the narcotic box to count and was never returned to the box. It was the belief that during the medication change over for the month the medication was somehow thrown away along with the empty medication cards from the previous month.

3. According to Staff A's statement, on 11-3-14 at 2:45 p.m. Staff A counted narcotics with Staff B. Staff A did not remember counting Tenant #1's narcotic medication. Staff A left the medication room several times due to people at the door and to assist a tenant in pain outside of the medication room. When Staff A came back Staff B said the count was finished and all was fine.

4. According to Staff B's statement, at 3:00 p.m. Staff B was counting medications with Staff A. Staff B counted the pills and Staff A (counted) with the book. Staff B did not remember counting the bottle of Tenant #1's medication because of the phone, pager and Staff A had to answer the door a few times so Staff B stopped the count until Staff A got back to the medication room.

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A 003	Continued From page 3 Staff B indicated there were too many distractions going on. Staff B indicated the medication count was not really counted the right way. Tenant #1's bottle was noted as missing when Staff B counted narcotic medications with the third shift staff. 5. According to an interview with the Nurse on 1-29-15 at 10:02 a.m., both staff involved in a narcotic medication count should be involved in both aspects of looking at the medications and looking at the book. 6. An incident report was not completed related to Tenant #1's missing Hydrocodone/APAP tablets. An Investigation Form-General was completed regarding the missing medications; however, an Incident Report form was not completed. The Investigation Form-General indicated the plan of action was to re-educate on the narcotic count policy and consequences for not following. 7. According to the Program's Controlled Substances policy and procedures, Schedule II controlled substances should be kept in accordance with federal and state law and regulations. Controlled substances would be stored under double lock, separate from all other medications with a separate key for access. Only authorized personnel should have access to controlled substances. Schedule II substances should be counted at the end of each shift and documented by each staff involved in the process. 8. According to the Program's Incident and Accident Report policy and procedure, all incidents and accidents was to be reported to the Director or the Nurse. Incidents or accidents should be documented on the Incident Report	A 003		

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A 003	Continued From page 4 form, immediately following the occurrence. The person in charge at the time of the incident or accident should prepare and sign it. The Incident Report should include statements from all witnesses, if any. 9. Tenant #3, an 88 year old, was admitted on 3-5-11 and diagnoses included: dementia Alzheimer's type, hypertension, hyperlipidemia, osteoporosis, history of compression fracture of spine and history of left total knee replacement. Tenant #3 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #3 received Hospice services and resided in the dementia unit. Tenant #3 was discharged. An Incident Report dated 1-21-15 at 10:30 p.m. indicated Tenant #3 was found on the floor in the fetal position on the right side. Tenant #3 was asked if Tenant #3 was having pain and Tenant #3 began sitting up. Tenant #3 sat up with the back against the bed. Staff assisted Tenant #3 back to bed. Tenant #3 barely helped to stand and was asked if Tenant #3 had pain. Tenant #3 refused cares due to pain in the right hand (ring finger). Tenant #3 also complained of pain to the right knee but only to touch. Tenant #3 was not able to move the right leg but could open and close the hand. Tenant #3 was able to move all other extremities. The Hospice nurse was notified and Hospice notified Tenant #3's family. Progress Notes dated 1-21-15 indicated the Nurse received a phone call from the Hospice nurse at 7:32 a.m. and it was reported Tenant #3 fell. The Hospice nurse came in and assessed Tenant #3 after the fall. Tenant #3's family did not want Tenant #3 sent out for evaluation and wanted to wait for the morning. Portable x-rays	A 003		

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A 003	Continued From page 5 were set up to be completed at the Program. The service plan dated 11-25-14 indicated (under Health Monitoring) to report any changes in condition to the Nurse. 10. According to Staff C's statement and interview on 1-28-15 at 3:06 p.m., regarding Tenant #3's fall, Staff D came in at 10:50 p.m. and Staff C wanted a second opinion on Tenant #3's condition and if it was an "okay reason" to call Hospice. Staff D called the Hospice nurse and the Nurse was not notified by staff regarding the incident with Tenant #3. 11. According to Staff D's statement and interview on 1-29-15 at 9:05 a.m., regarding Tenant #3's fall, Staff D arrived at 11:00 p.m. and Staff C who worked second shift was not sure what to do regarding Tenant #3 and asked for input. Staff D checked on Tenant #3 and when barely any pressure was on the leg Tenant #3 was in a lot of pain. Staff D notified the Hospice answering service just after 11:00 p.m. and did not receive a call back. Around 12:00 a.m. a Hospice nurse arrived to assess Tenant #3. Staff D said the Nurse was notified of the incident the next day by the Incident Report. 12. According to an interview with the Nurse on 1-29-15 at 10:02 a.m., staff called Hospice and did not call the Nurse regarding the incident with Tenant #3. Hospice notified the Nurse the next morning. Tenant #3's injuries included a right hip fracture and a right knee fracture. The Nurse said if there was a fall and the Nurse was in the building staff was to get the Nurse. If there was a fall and the Nurse was not in the building then Hospice would be the primary and staff was to call them. Staff would call the Nurse if there was	A 003		

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A 003	Continued From page 6 something they were not comfortable with. 13. There were no formal policies provided regarding nurse notification when outside agencies were involved including Hospice. Tenant #3's service plan dated 11-25-14 indicated to contact the Nurse to report any changes in condition. According to the Program's Medication Administration policy and procedure, significant changes in the tenant's health or behavior should be reported immediately to the Nurse. According to the Program's Incident and Accident Report policy and procedure, all incidents and accidents was to be reported to the Director or the Nurse.	A 003		
A 058	481-67.9(4)a 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: a. The program ' s newly hired registered nurse shall within 60 days of beginning employment as the program ' s registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on review of staff training documents and staff interviews the Program failed to document a review to ensure all staff was sufficiently trained and competent in tasks within 60 days of the Nurse's employment for six of six staff (Staff A, B, C, D, E and F). A review was not documented to	A 058		

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A 058	Continued From page 7 ensure all staff was sufficiently trained and competent in tasks within 60 days of the Nurse's employment for six staff. 1. According to the ALP Monitoring Entrance Form and the Employee Phone List, the Nurse was hired on 5-23-14. 2. Staff A, a certified medication aide (CMA), hired on 5-6-09, had nurse delegations completed by the Nurse on 11-14-14. The delegations included medication administration. The delegations were not completed within 60 days of the Nurse's employment. 3. Staff B, a CMA, hired on 6-10-11, had nurse delegations completed by the Nurse on 11-13-14. The delegations included medication administration. The delegations were not completed within 60 days of the Nurse's employment. 4. Staff C, a CMA, hired on 12-16-13, had nurse delegations completed by the Nurse on 11-14-14. The delegations included medication administration. The delegations were not completed within 60 days of the Nurse's employment. 5. Staff D, a CMA, hired on 10-29-12, did not have documented nurse delegations or a review to ensure training and competency completed by the Nurse 6. Staff E, a CMA, hired on 4-22-11, did not have documented nurse delegations or a review to ensure training and competency completed by the Nurse. 7. Staff F, a CMA, hired on 5-30-12, did not have	A 058		

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A 058	Continued From page 8 documented nurse delegations or a review to ensure training and competency completed by the Nurse. 8. According to an interview with the Director on 1-28-15 at 4:36 p.m., Staff D, E and F did not have nurse delegations completed by the Nurse. 9. According to an interview with the Nurse on 1-29-15 at 10:02 a.m., staff provided assistance with activities of daily living, treatments and medications. The Nurse said staff training was completed; however, was not documented.	A 058		

Plan of Correction
Davenport Bickford

A. (A 003) Program policies and procedures
Regulatory Insufficiency: The Program failed to follow Program policies and procedures regarding narcotic medication count, completion of an Incident report and nurse notification of an incident.

Plan of Correction:
The insufficiency will be corrected as follows:
- Mandatory staff meeting was held on 2/13/15. Staff have been re-educated regarding:
  - contacting Branch RNC for all incidents, including those on hospice services
  - completion of Incident Report
  - Certified Medication Aides--on proper narcotic count

The following measures will be taken to ensure the problem does not recur:
- Director will review all Incident Reports to ensure RNC/Director notification has been completed.
- RNC to observe shift change narcotic count on each shift once a month and as needed.

The program will monitor performance to ensure compliance as follows:
- Divisional RN to review Incident Reports biannually to ensure completion per policy.
- Divisional RN will perform core checks on med pass biannually to monitor for compliance.

Date deficiencies corrected by: 02/13/15

B. (A 058) Staffing
Regulatory Insufficiency: The Program failed to document a review to ensure all staff was sufficiently trained and competent in tasks within 60 days of the Nurse's employment.

Plan of Correction:
The insufficiency will be corrected as follows:
- RNC will ensure all staff are sufficiently trained and competent in tasks as assigned, utilizing nurse delegation as appropriate.
- All staff will have appropriate nurse delegation completed by the RNC by March 6, 2015.

The following measures will be taken to ensure the problem does not reoccur:
- Director to review staff files to ensure all delegation of current staff is completed by 3/6/15.
- All new hires will complete nurse delegations during onboarding process, prior to working on the floor and as appropriate on an on-going basis.

The Program will monitor performance to ensure compliance as follows:
- Divisional Operations to review employment files biannually.
- Divisional RN will review nurse delegations biannually during core checks.

Date deficiencies corrected by: 3/6/2015