IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
55920-I

January 14, 2016

Ms. Kristen Trotter, Director
Bickford Cottage Cedar Falls
5101 University
Cedar Falls, IA 50613

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

Dear Ms. Trotter:

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 **December 22, 23 and January 4, 2016.** The Report notes Regulatory Insufficiencies in the area(s) of: Program policies and procedures, Service Plans and Nurse Review.

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
	S0028	A. BUILDING: _____ B. WING _____	C 01/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

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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: 21 Number of tenants with cognitive disorder: 16 Total Population of Program at time of on-site: 37 TOTAL census of Assisted Living Program: 37 An investigation of Incident #55920-I was completed. There were regulatory insufficiencies identified related to Incident #55920-I and during the course of the investigation.	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 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 and review of Program documents the Program	A 003		

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A 003	Continued From page 1 failed to follow their policy regarding the completion of incident reports regarding an alleged incident that occurred between two tenants (Tenants #1 and #2). An alleged incident of inappropriate touching occurred between two tenants and an incident report was not completed in the timeframe specified in the Program's policy. 1. Tenant #1, a 77 year old, was admitted on 7-14-15 and had a diagnosis of dementia. Tenant #1 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. 2. Tenant #2, a 79 year old, was admitted on 5-30-12 and diagnoses included: chronic obstructive pulmonary disease, peripheral vascular disease, acute hepatic failure, hyperlipidemia, osteoporosis, Raynaud's Phenomenon, acne rosacea and seizure. Tenant #2 scored a 30/30 on the Mini Mental Status Examination. Tenant #2 was discharged on 10-30-15. 3. According to an incident report dated 10-20-15, Staff A went to Tenant #1's apartment to assist Tenant #1 with medications. Tenant #1 was at the door and Tenant #2 was behind the door in Tenant #1's apartment. Tenant #1 asked Tenant #2 to leave in a stern voice and Tenant #2 exited the apartment. Tenant #1 said Tenant #1 told Tenant #2 no and Tenant #2 stayed. Tenant #1 alleged Tenant #2 inappropriately touched Tenant #1. According to an investigation form, the date reported was 10-15-15 and the type of occurrence was an allegation of abuse. An	A 003		

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A 003	Continued From page 2 incident report was received on 10-20-15 regarding an incident reported to the Nurse on 10-15-15. The incident report read differently than what was reported verbally on 10-15-15. The incident report indicated Tenant #1 told Tenant #2 no and Tenant #2 stayed and allegedly touched Tenant #1 inappropriately. Interviews were completed with the tenants involved and all staff. The plan of action included: 24 hour supervision initiated immediately to ensure tenant safety, the service plan was updated to reflect behavior and provide interventions for staff. Counseling was provided for staff to ensure understanding of the difference between initial report and incident report and why it was important. 4. On 10-20-15 the Program completed interviews with Tenant #1 and Tenant #2. Tenant #1 did not remember Tenant #2 in Tenant #1's apartment the week prior to the interview. Tenant #1 was not afraid of anyone and denied anyone had touched Tenant #1 while in Tenant #1's apartment. Tenant #1 denied anyone of the opposite sex was bothering Tenant #1. Tenant #2 initially denied being in Tenant #1's apartment. Tenant #2 was told one of the staff saw Tenant #2 in Tenant #1's apartment the week prior to the interview. Tenant #2 said Tenant #1 asked Tenant #2 to go into Tenant #1's apartment to throw away a plastic cup. Tenant #1 was sweeping the floor in the hallway. Tenant #2 denied touching Tenant #1 in Tenant #1's apartment. 5. According to Staff A's written statement, on 10-14-15 Staff A knocked on Tenant #1's door and Tenant #1 opened the door. Staff A stood	A 003		

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A 003	Continued From page 3	A 003		

there for about 10 seconds and told Tenant #1 Staff A needed to come in to assist with Tenant #1's medications. Tenant #1 moved back away from the door and let Staff A in the apartment. When in the apartment Staff A noticed Tenant #2 standing behind the door with Tenant #2's assistive device. Tenant #1 asked Tenant #2 to leave and as Tenant #2 was leaving Tenant #2 said Tenant #2 would see Tenant #1 later. Tenant #1 responded and said "Oh, No you won't!" Tenant #1 walked over to the dresser to take Tenant #1's medication. During that time Tenant #1 had both hands moving and was talking to Staff A. Tenant #1 said Tenant #2 had put Tenant #2's hands on Tenant #1 waist. While Tenant #1 was talking Tenant #1's hands moved to another area of Tenant #1's body. Tenant #1 told Staff A that Tenant #1 told Tenant #2 no, to get out and to never come back.

According to an Program interview completed with Staff A on 10-20-15, Staff A notified the Nurse of the alleged incident on 10-15-15 and it occurred on 10-14-15. Staff A was instructed by the Nurse to complete an incident report. Staff A asked if Staff A could hand in the incident report tomorrow and was told yes.

6. According to an interview with Staff A, Staff A went to Tenant #1's apartment and knocked. Tenant #1 was right there and backed up enough to let Staff A in the apartment. Tenant #2 was by the kitchen area and had Tenant #2's assistive device. Tenant #1 said Tenant #2 needed to leave and Tenant #1 seemed frustrated and mad. Tenant #2 left the room and said Tenant #2 would see Tenant #1 later and Tenant #1 said no Tenant #2 would not. Tenant #1 made a comment about people of the opposite sex and then touched

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A 003	Continued From page 4 areas of Tenant #1's body. Tenant #1 and Tenant #2 were fully clothed and Staff A did not witness any touching between them. Staff A reported it to the Nurse either that day or the next day. 7. According to the interview with the Nurse, Staff A reported to the Nurse that Staff A went to Tenant #1's apartment and Tenant #2 was standing behind the door and when Staff A came in Tenant #2 left. Staff A reported Tenant #1 said Tenant #2 had patted Tenant #1's waist area and Tenant #1 told Tenant #2 no. It was reported Tenant #2 had stopped per the verbal report from Staff A. Staff A could not find the Nurse the day of the alleged incident and reported it the day after. The Nurse told Staff A to write an incident report and Staff A asked if Staff A could write the incident report the next day. The incident report was not received until Monday (10-20-15). When the incident report was reviewed it read differently than what was reported verbally. The incident report indicated Tenant #2 did not stop when asked. The allegation was submitted to the Department and the Program initiated an investigation. Interviews were completed with Tenants #1,#2 and staff. Private duty staff was provided 24 hours a day for Tenant #2 for safety. Tenant #2 moved out of the Program. Re-education was provided for staff. 8. According to the Director, the Nurse called the Director on Monday (10-20-15) because an incident report was received regarding the alleged incident between Tenant #1 and #2 and it was different than what was reported to the Nurse verbally on the Wednesday prior. Staff A did not write the incident report for the alleged incident until Monday (10-20-15). An investigation was started including the	A 003		

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A 003	Continued From page 5 completion of staff interviews and interviews with Tenant #1 and Tenant #2. Re-education was provided for staff. Tenant #2 had 24 hour care, which was to be provided until the Department investigated the incident. Tenant #2 moved out of the Program. 9. According to Program documents, the alleged incident occurred on 10-14-15. The Nurse was notified on 10-15-15. The incident report was dated 10-20-15 regarding the alleged incident on 10-14-15. According to timecard records, Staff A worked on 10-14-15, 10-16-15, 10-17-15, 10-18-15, 10-19-15 and 10-20-15. 10. According to the Program's policy and procedure regarding incident reports, tenant, staff or visitor incidents or accidents were to be reported and documented immediately after they occurred. Incidents and accidents included but were not limited to medication errors, staff or visitor injuries and tenant falls or injuries. All incidents or accidents were to be reported to the Director or the Nurse. Incident reports would be documented on the incident report form immediately following the occurrence. The person in charge at the time of the incident or accident would prepare and sign the report. The report would include statements from all witnesses if any. Any incident also needed to be documented in Progress Notes and vital signs would be taken and documented on each incident report.	A 003		
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 089		

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A 089	Continued From page 6 a. The tenant ' s identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on review of tenant files, staff interviews and review of Program documents the Program failed to develop service plans that reflected the identified needs of the tenants for three of five tenant files reviewed (Tenants #1, #2 and #4). Three tenants did not have service plans that reflected their identified needs. 1. Tenant #1, a 77 year old, was admitted on 7-14-15 and had a diagnosis of dementia. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. According to an incident report dated 10-20-15, Staff A went to Tenant #1's apartment to assist Tenant #1 with medications. Tenant #1 was at the door and Tenant #2 was behind the door in Tenant #1's apartment. Tenant #1 asked Tenant #2 to leave in a stern voice and Tenant #2 exited the apartment. Tenant #1 said Tenant #1 told Tenant #2 no and Tenant #2 stayed. Tenant #1 alleged Tenant #2 inappropriately touched Tenant #1. According to an investigation form, the date reported was 10-15-15 and the type of occurrence was an allegation of abuse. An incident report was received on 10-20-15 regarding an incident reported to the Nurse on 10-15-15. The incident report read differently than what was reported verbally on 10-15-15. The incident report indicated Tenant #1 told	A 089		

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A 089	Continued From page 7 Tenant #2 no and Tenant #2 stayed and allegedly touched Tenant #1 inappropriately. Interviews were completed with the tenants involved and all staff. The plan of action included: 24 hour supervision initiated immediately to ensure tenant safety, the service plan was updated to reflect behavior and provide interventions for staff. Tenant #1's service plan was not updated after the alleged incident between Tenant #1 and Tenant #2 to reflect interventions related to the alleged incident. The service plan did not reflect the identified needs of Tenant #1. 2. Tenant #2, a 79 year old, was admitted on 5-30-12 and diagnoses included: chronic obstructive pulmonary disease, peripheral vascular disease, acute hepatic failure, hyperlipidemia, osteoporosis, Raynaud's Phenomenon, acne rosacea and seizure. Tenant #2 scored a 30/30 on the Mini Mental Status Examination. Tenant #2 was discharged on 10-30-15. According to interviews with the Director and the Nurse, Tenant #2 had a history of consensual relationships with other tenants prior to the alleged incident between Tenant #1 and Tenant #2. Tenant #2's service plan was updated on 10-21-15, after the alleged incident between Tenant #1 and Tenant #2. The service plan reflected private duty care provided 24 hour supervision and Tenant #2 had a history of consensual relationships with other tenants. The service plan dated 9-10-15 (which was the service plan in effect at the time of the alleged	A 089		

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A 089	Continued From page 8 incident) did not reflect the history of consensual relationships with other tenants. The service plan did not reflect the identified needs of Tenant #2. 3. Tenant #3, an 85 year old, was admitted on 3-7-15 and had a diagnosis of intracranial hemorrhage. Tenant #3 was staged at a five on the GDS, which indicated moderately severe cognitive decline. 4. Tenant #4, a 91 year old, was admitted on 4-18-11 and diagnoses included: dementia Alzheimer's, anxiety and depression. Tenant #4 was staged at five on the GDS, which indicated moderately severe cognitive decline. Tenant #4 received Hospice services. According to an incident report dated 12-1-15, the Nurse was informed Tenant #4 was found in Tenant #3's apartment without Tenant #4's pants on and Tenant #3's shirt was unbuttoned. Tenant #3's service plan was updated on 12-2-15 and reflected Tenant #3 paid close attention to Tenant #4 and thought Tenant #4 was Tenant #3's parent. If staff saw Tenant #3 standing beside Tenant #4 to redirect Tenant #3 to another activity or ask Tenant #4 if Tenant #4 would like assistance to Tenant #4's apartment or another area. Tenant #3 had a history of attempting sexual contact with other tenants, if staff observed Tenant #3 go into an apartment with another tenant to redirect Tenant #3 using spontaneous activities. Tenant #3 was not capable of giving consent to have sexual relationships. Tenant #3 hovered around Tenant #4. Tenant #3 was not to be around Tenant #4, per family and tenant request.	A 089		

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A 089	Continued From page 9 The service plan for Tenant #3 reflected the behavior and interventions for Tenant #3; however, the service plan for Tenant #4 did not reflect the behavior between Tenant #3 and Tenant #4 and interventions related to the behavior. The service plan did not reflect the identified needs of Tenant #4. 5. According to the Program's policy and procedure regarding assessments, the assessment/service plan would be completed to identify the following: services to be provided, supplemental services, service level, monthly rate and any applicable managed risk agreements.	A 089		
A 096	481-69.27(3) Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant ' s condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(3) To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant ' s health status This REQUIREMENT is not met as evidenced by: Based on review of tenant files and review of Program documents the Program failed to assess and document the health status of each	A 096		

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A 096	Continued From page 10 tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there were changes in the tenant's health status for one of five tenant files reviewed (Tenant #1). Tenant #1 reported an alleged incident of a sexual nature between Tenant #1 and Tenant #2 and a nurse review was not completed as needed for Tenant #1, including an assessment of any injuries. 1. Tenant #1, a 77 year old, was admitted on 7-14-15 and had a diagnosis of dementia. Tenant #1 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. 2. Tenant #2, a 79 year old, was admitted on 5-30-12 and diagnoses included: chronic obstructive pulmonary disease, peripheral vascular disease, acute hepatic failure, hyperlipidemia, osteoporosis, Raynaud's Phenomenon, acne rosacea and seizure. Tenant #2 scored a 30/30 on the Mini Mental Status Examination. Tenant #2 was discharged on 10-30-15. 3. According to an incident report dated 10-20-15, Staff A went to Tenant #1's apartment to assist Tenant #1 with medications. Tenant #1 was at the door and Tenant #2 was behind the door in Tenant #1's apartment. Tenant #1 asked Tenant #2 to leave in a stern voice and Tenant #2 exited the apartment. Tenant #1 said Tenant #1 told Tenant #2 no and Tenant #2 stayed. Tenant #1 alleged Tenant #2 inappropriately touched Tenant #1. According to an investigation form, the date	A 096		

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A 096	Continued From page 11 reported was 10-15-15 and the type of occurrence was an allegation of abuse. An incident report was received on 10-20-15 regarding an incident reported to the Nurse on 10-15-15. The incident report read differently than what was reported verbally on 10-15-15. The incident report indicated Tenant #1 told Tenant #2 no and Tenant #2 stayed and allegedly touched Tenant #1 inappropriately. 4. According to Tenant #1's Progress Notes dated 10-20-15 (late entry for 10-15-15) the Nurse spoke with Tenant #1 in Tenant #1's apartment. Tenant #1 was asked if there was someone bothering Tenant #1. Tenant #1 said Tenant #1 was out with other tenants and they all liked a person but Tenant #1 told the person to leave Tenant #1 alone. Reassurance was provided to Tenant #1 that the situation would be monitored and to let staff know if anyone bothered Tenant #1 again. According to Tenant #1's Progress Notes dated 10-20-15, Tenant #1 was asked if anyone had been bothering Tenant #1 and Tenant #1 said no. Tenant #1 could not remember if there was a person of the opposite sex in Tenant #1's apartment the week prior. Tenant #1 denied being fearful of anyone, denied any pain and there were no signs or symptoms of injury. A nurse review was not completed at the time of the alleged incident to assess Tenant #1 for any injury or change in health status. A nurse review was not completed as needed. 5. According to the Program' policy and procedure regarding nurse reviews, a nurse review would be completed on every tenant at least every 90 days or after a change in	A 096		

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
	S0028	A. BUILDING: _____ B. WING _____	C 01/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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 096	Continued From page 12 condition. A nurse review would include the following: assessment and documentation of the health status of the tenant, make recommendations and referrals as appropriate and monitor the progress of previous recommendations.	A 096		

Plan of Correction
Cedar Falls Bickford Cottage

A. Program Policies and Procedures
Regulatory Insufficiency: The Program failed to follow their policy regarding the completion of incident reports regarding an alleged incident that occurred between two tenants.

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

- All incidents or accidents will be reported and documented immediately after they occur.

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

- The RNC was re-educated specifically as it relate to when an incident should be reported.
- All staff attended an in-service training on documentation, service plans and incident reports, including the timely reporting and documenting of incidents.
- Documentation of training will be maintained in their personnel file.

The program will monitor performance to ensure compliance as follows:

- In-services will be done annually on documentation, incident reports, and service plans
- The Divisional Director of Operations will audit employee files, at least twice a year, for appropriate training documentation.

The date by which the regulatory insufficiency will be corrected:

- Incident Report completion training occurred on 11/11/2015.

B. Service Plans
Regulatory Insufficiency: The Program failed to develop service plans that reflected the identified needs of three tenants.

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

- The RNC, in conjunction with the Director will develop Service Plans that reflect the needs/desires of residents that have been assessed as part of the evaluation process.

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

- The Director and RNC were re-educated on utilizing the assessed needs of residents, at the time of any significant change in the resident's condition, to develop a Service Plan to meet those needs.
- Further instruction was provided to all staff regarding the use of Service Plans.

The program will monitor performance to ensure compliance as follows:

- The Director and RNC will observe/monitor staff to determine appropriate provision of care is occurring and that staff have the necessary tools to appropriately meet the needs of residents.
- Divisionals will audit personnel files to ensure that appropriate training is occurring and being documented and Service Plans to see that they meet the resident's assessed needs, at least annually.

The date by which the regulatory insufficiency will be corrected:

- Service Plan training occurred on 01/04/2016.

B. Nurse Review

Regulatory Insufficiency: The Program failed to assess and document the health status of each tenant, to make recommendations and referrals as appropriate and to monitor progress relating to previous recommendations at least every 90 days and whenever there were changes in the tenant's health status.

Plan of Correction:

The insufficiency will be corrected as follows

- The RNC will perform a nurse review to meet State requirements every 90 days and as needed when a significant change occurs.

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

- The RNC was re-educated by the Divisional Director of Resident Services on the criteria for a nurse review.

The program will monitor performance to ensure compliance as follows:

- Resident's charts are audited by the Divisional at least annually to ensure Nurse Reviews are being completed when necessary.

The date by which the regulatory insufficiency will be corrected:

- The retraining for the RNC occurred on 01/04/2016