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 12/04/2017

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 000	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: 23 Number of tenants with cognitive disorder: 13 Total Population of Program at time of on-site: 36 TOTAL census of Assisted Living Program: 36 During the investigation of Incident #71461-I, regulatory insufficiencies were cited	A 000	See attached POC 1/17/18	
A 012	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure all tenants were treated with consideration, respect, and full recognition of personal dignity and autonomy for 2 of 2 tenants reviewed (Tenants #1 and #2). Findings follow: 1. Record review revealed an Investigation Form, dated 9-20-17, documented on 9-19-17 at about 6:00 p.m. staff witnessed Staff B tell Tenant #1 he/she could not have a hamburger because he/she refused food earlier that evening. Staff B was suspended pending the completion of the	A 012		

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A 012	Continued From page 1 investigation. When interviewed on 11-30-17 at 2:32 p.m. Staff C revealed an incident occurred during second shift in the dining room between Staff B and Tenant #. Staff C reported around 6:00 p.m., an hour after dinner, Tenant #1 walked toward the kitchen and said he/she was hungry. Staff B reportedly yelled across the room at Tenant #1 that he/she could not have anything. Staff B's tone was very aggressive. Staff D went to Tenant #1 to ask what he/she wanted, as Tenant #1 yelled to Staff B to leave him/her alone. Staff E stepped in and said Tenant #1 could have what he/she wanted. When interviewed on 11-30-17 at 4:06 p.m., Staff E reported she was in the dining area with Staff B, Staff C, and Staff D around 6:00 p.m. - 6:30 p.m. when Tenant #1 came to staff and asked for something to eat. Tenant #1 had not eaten his/her dinner that evening. Staff B reportedly told Tenant #1 he had his/her food, he/she didn't want it, and he/she would have to wait. Staff E told Tenant #1 he could have whatever he/she wanted to eat and told staff to get it for him/her. Staff E reported Staff B was very gruff and annoyed regarding the incident, and the interaction went on for about five minutes. When interviewed on 11-30-17 at 11:34 a.m., Staff D reported Tenant #1 did not eat his/her dinner that evening. He/she came to the dining room around 6:00 p.m., as staff sat down for break. Staff D asked Tenant #1 if he/was was hungry and wanted a hamburger. Staff B reportedly then told Tenant #1 he/she didn't eat the food he had already been given in a stern voice. Staff D then went to make Tenant #1 a hamburger, which he/she ate.	A 012		

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A 012	Continued From page 2 Staff B was unavailable for interview by the monitor; however, continued record review revealed Staff B's statement indicated staff were on break in the dining room. Tenant #1 said he/she wanted a hamburger; however, earlier during the evening meal Tenant #1 refused the hamburger. Staff B asked Tenant #1 to sit down and finish the meal, but Tenant #1 said he/she was full. Tenant #1 refused the evening meal regularly due to drinking coffee and eating snacks all day. Tenant #1 also forgot he/she drank and ate all day. Staff B indicated Tenant #1 wanted a hamburger and Staff B told him/her no and that he/she had refused the hamburger at the evening meal. Tenant #1 was offered a peanut butter and jelly (sandwich) or to wait and eat ice cream at 7:30 p.m. Tenant #1 said no and that he/she wanted a hamburger. Staff B reminded him/her again that he/she had refused the hamburger a half hour before and that ice cream would be provided shortly. Staff B indicated Tenant #1 said "Fine! I guess I will wait." Another staff said to Tenant #1 that she would get him/her a hamburger. Staff B indicated she told her to give Tenant #1 two but she doubted he/she would eat one. During an additional interview on 9-21-17, Staff B indicated she joked with Tenant #1 and always joked with him/her. Staff B reported she did not yell at Tenant #1, though it may have been loud as the room was empty. When interviewed on 12-4-17 at approximately 9:30 p.m., the Director confirmed Staff B's interaction with Tenant #1 was inappropriate. The Program's internal investigation revealed staff who witnessed the alleged incident had consistent statements regarding Staff B's behavior. As a result, Staff B was terminated.	A 012		

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A 012	Continued From page 3 2. Record review revealed an investigation form, dated 9-25-17, revealed the Nurse received a telephone call from Tenant #2's family member who reported over the weekend Tenant #3's family member overheard Staff B tell Tenant #2 to "get off his/her ass" and spoke to Tenant #2 in a degrading manner. Continued record review revealed the Program's investigation included a statement from Tenant #3's family member. The statement, dated 9-25-17, indicated the following was heard: "You would feel better if you would get off your butt." When interviewed by the Program, the family member reported Staff B was loud in her remarks to Tenant #2, but questioned the tenant's ability to hear. Further review of the Program's investigation revealed Tenant #2's family member provided a written statement. The statement indicated when the family member arrived at the Program Tenant #2 sat on the edge of the bed, was very upset, crying and shaking. Tenant #2 reported to his/her family member Staff B had come into his/her apartment, was mad and yelled at him/her. Staff B tried to tell him/her to do something and he/she did not want to do it and Staff B got very mad. The family member approached Staff B and Staff B reported she did not know what happened. The statement also indicated Tenant #2's family member was approached by Tenant #3's family member to report Staff B yelled at Tenant #2 and spoke to him/her in a derogatory manner. Staff B was unavailable for interview; however, Staff B's statement indicated Tenant #2's family member approached her and reported Tenant #2 was upset and was crying and asked if she had been in there. Staff B said she had briefly been in	A 012		

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A 012	Continued From page 4 there and asked him/her if she wanted a pain pill. Staff B told Tenant #2 he/she should lay down to take the pressure off of his/her bottom. Staff B reported she told Tenant #2 the sore on his/her bottom would not heal if he/she sat on it all day and many days she told him/her the doctor wanted him/her to lay down and only to be up for meals. Staff B reported Tenant #2 rarely refused to lay down when reminded how big the sore was and that it couldn't heal if he/she didn't follow doctor's orders. When interviewed on 12-4-17 at approximately 9:30 a.m. the Director reported Staff B's tone with Tenant #2 was inappropriate.	A 012		
A 071	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure consistent and appropriate documentation of treatment orders for 1 of 2 tenants reviewed (Tenant #2). Findings follow: 1. Record review revealed Tenant #2 diagnoses	A 071		

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A 071	Continued From page 5	A 071		

included: chronic dementia and a stage 4 decubitus ulcer of coccygeal region. Tenant #2 was staged at a three on the Global Deterioration Scale, which indicated mild cognitive decline.

Continued record review revealed the following:

a. A physician's order, dated 8-22-17, directed to dress the coccyx with Puracol plus AG and cover with Tegaderm every other day. The order was noted on 8-23-17.

Further record review revealed the order not transcribed to the treatment administration records (TAR). No documentation of completion of the treatment could be located from 8-24-17 through the end of August.

b. A physician's order, dated 10-14-17, ordered complete wet to dry dressing change to the stage 4 pressure ulcer to the coccyx daily until Tenant #2's appointment at the wound clinic on 10-18-17. The order was noted on 10-17-17.

Further record review revealed the order not transcribed to the TAR and not documented as completed. Documentation of the completion of the physician ordered treatment on the October TAR could not be located.

c. A faxed physician's order, dated 11-8-17, ordered the following: "...stop packing the site. On bath days remove all dressings. Shower or whirlpool then fluff calcium alginate to the wound bed and fill the cavity with calcium alginate, cover with adhesive sacral foam." According to the order, the dressing should be changed two times per week. The order was signed on 11-14-17 and noted on 11-14-17.

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A 071	Continued From page 6 Continued record review revealed the order not transcribed to the TAR until 11-28-17. The TAR reflected the order with a start date of 11-28-17 and a stop date of 11-28-17. No documentation of completion of the physician ordered treatment on the November TAR could be located. When interviewed on 12-4-17 at approximately 10:00 a.m., Staff A, a licensed practical nurse, revealed she assisted while the Nurse was gone and was not familiar with the system of faxing orders to the pharmacy to have the order placed on the TAR. Staff A reported Tenant #2 received all of the wound care as ordered.	A 071		

Plan of Correction
Bickford Cottage Cedar Falls

HEALTH FACIL
JAN 03 2018

A 012-Tenant Rights

Regulatory Insufficiency: Program failed to ensure all tenants were treated with consideration, respect, and full recognition of personal dignity and autonomy.

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

- Staff B's employment was suspended on 09/20/2017 pending completion of the investigation and terminated 10/16/17.

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

- Director will provide education to all staff on Abuse Reporting guidelines during the next in-service, 1/17/18.

The program will monitor performance to ensure compliance as follows:

- The Director will ensure 100% staff participation in Abuse Reporting Guidelines education.

Date deficiencies corrected: 1/17/18

A 071-Tenant Documents

Regulatory Insufficiency: Program failed to ensure consistent and appropriate documentation of treatment orders.

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

- Divisional Director of Resident Services provided education to Staff A 12/22/17 on Documentation Guidelines for treatment orders.

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

- Divisional Director of Resident Services or RNC will provide education to Certified Medication Aides regarding Documentation Guidelines for treatment orders by 12/28/17.

The program will monitor performance to ensure compliance as follows:

- The RNC will review resident Treatment Administration Records weekly for compliance.

Date deficiencies corrected: 12/28/17