DEPARTMENT OF INSPECTIONS AND APPEALS

5/30/18 OK 5/29/18

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 _____	R-C 04/10/2018

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}	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: 26 Number of tenants with cognitive disorder: 2 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 6 TOTAL Census of Assisted Living Program for People with Dementia : 34 The following regulatory insufficiencies were cited during the revisit of incident #72417-I, complaint #72385-C and the revisit of complaints #67802-C, #67817-C and #69006-C.	{A 000}	See attached POC 5/15/18	
{A 040}	481-69.23(1)c(1) Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	{A 040}		

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{A 040}	Continued From page 1 Program failed to identify and take timely action to discharge tenants who displayed chronically aggressive or abusive behavior, despite intervention, which compromised the safety and security of tenants residing at the Program. This pertained to 3 of 3 tenants reviewed who chronically displayed verbal and/or physical aggression (Tenants #3, #4 and #5). Findings follow 1. Record review of Tenant #3's file revealed the following: a. A 30 day notice of discharge was issued on 3-6-18 after the Program was cited on 2-22-18 for failing to discharge Tenant #3 due to chronically aggressive and/or abusive behavior. b. Progress notes dated 3-28-18 indicated staff reported another assisted living program evaluated Tenant #3 on 3-23-1, but no decision was known. The note also documented the Nurse spoke to a nursing home who stated they would not be able to accept Tenant #3. The nursing home stated the family was aware. c. A fax to Tenant #3's physician, dated 3/15/18, documented Tenant #3 became agitated towards staff telling them to leave his/her house. Staff indicated the tenant became agitated when she saw staff get paper towels. Staff reported Tenant #3 kicked her in the calf. d. A fax to Tenant #3's physician on 3/22/18 documented Tenant #3 became agitated with another tenant when he/she attempted to feed another resident and staff redirected him/her. Tenant #3 swung at staff. e. Progress notes documented on 4/7/18 at 3:30 p.m. Tenant #3 became agitated with another	{A 040}		

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{A 040}	Continued From page 2	{A 040}		

tenant and hit him/her in the face and arm.

f. Progress notes documented on 4/7/18 at 4:45 p.m. Tenant #3 tried to throw a punch at another tenant when he/she blew his/her nose. Staff stepped in front of Tenant #3 and the other tenant, and took the hit.

g. Progress notes documented on 4/8/18 Tenant #3 approached another tenant in the dining room and yelled at them to leave his/her home. Tenant #3 told the other tenant he/she would call the police and escort him/her out if needed. Staff attempted to redirect Tenant #3, without success.

No further entries were documented regarding Tenant #3's discharge plans. Tenant #3 continued to reside at the Program.

2. Record review of Tenant #4's file revealed the following:
a. A 30 day notice of discharge was issued on 3-5-18 after the Program was cited on 2-22-18 for failing to discharge Tenant #3 due to chronically aggressive and/or abusive behavior.

b. Progress Notes dated 3-28-18 documented an assisted living program denied Tenant #4. A nursing home was coming to evaluate and another nursing home and rehabilitation center requested information be faxed.

No further entries were documented regarding Tenant #4's discharge plans. Tenant #4 continued to reside at the Program.

3. Record review of Tenant #5's file revealed the following:

a. A 30 day notice of discharge was issued

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{A 040}	Continued From page 3 3/5/18 after the Program was cited on 2/22/18 for failure to discharge Tenant #5 due to chronically aggressive and/or abusive behavior. b. Progress notes on 3/10/18 documented Tenant #5 pinched, scratched and spit while staff assisted her with dressing. c. Progress notes on 3/20/18 documented Tenant #5 yelled at staff to "Get the hell out of (his/her) room!,"and attempted to hit them. d. Progress notes on 3/27/18 documented Tenant #5's family requested hospice services. An evaluation was requested and the physician notified. e. Progress notes documented on 3/28/18 a nursing home indicated Tenant #5 did not qualify for their Alzheimer's unit due to Tenant #5 not wandering and not being an elopement risk. The nursing home further stated Tenant #5 was eligible for a long term care (LTC) bed, but they did not currently have any available. Tenant #5 was placed on the waiting list for a bed. The progress note further documented Tenant #5 was denied placement at an assisted living program. f. Progress notes on 3/28/18 at 2:00 p.m. documented an order for Tenant #5 to receive hospice and a referral made to a hospice provider. At 4:00 p.m. notes documented Tenant #5 would begin hospice services 3/31/18. No further entries were documented regarding Tenant #5's discharge plans. Tenant #5 continues to reside at the Program. 4. When interviewed on 4/9/18 at 2:25 p.m., the	{A 040}		

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{A 040}	Continued From page 4 Nurse stated the tenant's families were picky about where they wanted the tenants to go. She received calls from an assisted living program, so she knew they were coming to evaluate and the families would not move on until after the assisted living completed their evaluation. She stated Tenant #5 was on a waiting list for a long term care bed and there were a couple others on the waiting list ahead of Tenant #5. According to the Nurse, the assisted living and nursing home denied placement for Tenant #3. The nurse planned to call the family to ask what they were doing; especially since a physical incident occurred this past weekend between Tenant #4 and another tenant. The nurse stated the hospital did not think Tenant #3 was appropriate for a geriatric psychiatric unit and the hospital thought assisted living was appropriate. The Nurse reported Tenant #4's evaluations by the assisted living and a nursing home denied placement. Another nursing home was scheduled to come in on April 9th or 10th. She stated the families wanted to take care of things themselves but she did assist Tenant #4's family after they had called a nursing home and didn't understand the acronyms the nursing home used. On 4-10-18 at 10:50 a.m. the Nurse stated a nursing home and rehabilitation center informed her they would come to the Program on 4-11-18 at 10:00 a.m. to evaluate Tenant #4. 5. When interviewed on 4-10-18 at 10:57 a.m., the Divisional Director of Resident Services stated she had a weekly phone call with the nurse. During last week's call it was reported Tenant #3 had at least two outside providers assess the tenant for placement and both denied acceptance. They continued to work with	{A 040}		

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{A 040}	Continued From page 5	{A 040}		

geriatric psychiatry and Tenant #3 recently had an appointment, possibly on 4-4-18. Last week a provider came for an assessment but Tenant #3 wouldn't wake up so the assessment could not be completed. That provider should be back this week.

The Divisional Director of Resident Services stated Tenant #4 was denied by one provider and a second was supposed to evaluate. Information had been faxed to another provider.

She reported Tenant #5 was assessed and denied by one provider and was on a waiting list with another. The nurse called and verified Tenant #5's placement on the wait list. Since then Tenant #5 was admitted to hospice. Medication changes were made. The nurse asked hospice to assist with placement. The family also checked with another provider, but they had not yet come to do the assessment.

According to the Divisional Director of Resident Services, Tenants #3, #4 and #5 did not have discharge dates at this time.

6. When interviewed on 4-10-18 at 11:07 a.m., the Divisional Director of Operations reported 30 day notices were given to Tenants #3, #4 and #5 when the plan of correction was received. Meetings were held with families and they were told there was no appeal process. Names of other providers were given to the families and releases of information forms were signed. There were denials for placement, but the Program continued to help families find placements. One tenant was on a waiting list. The Program continued with interventions, medication changes and geriatric psychiatric follow up so the Program could continue to

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{A 040}	Continued From page 6 provide care while the tenants resided at the Program. According to the Divisional Director of Operations, no discharge dates were set for Tenants #3, #4 and #5.	{A 040}		

5/30/18 OK 5/29/18

Plan of Correction
Muscatine Bickford Cottage

A040—Criteria for Admission/Retention of Tenants
Regulatory Insufficiency: Program failed to identify and take timely action to discharge tenants who displayed chronically aggressive or abusive behavior, despite intervention, which compromised safety and security of tenants residing at the Program.

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

- Resident #3 was provided a Level of Care Discharge Notice on 3/6/18 and has been assessed by four Memory Care facilities who have declined admission.
- Resident #4 was provided a Level of Care Discharge Notice on 3/5/18, has been accepted by Lutheran Home Living and family is arranging discharge.
- Resident #5 was provided a Level of Care Discharge Notice on 3/5/18, has been accepted by Lutheran Home Living and family is arranging discharge.
- RNC has provided the POA's of resident #3, #4 and #5 with a second listing of Iowa Skilled Nursing Facilities and Memory Care Units within the Muscatine area and surrounding communities.
- RNC has provided re-education with POA's of resident #3, #4, #5 regarding Level of Care Discharge Notice and need for Long Term Care placement.
- RNC has contacted Iowa Skilled Nursing Facilities/Memory Care Units within the area and surrounding communities regarding Memory Care bed availability and will provide information to resident POA's.
- Divisional Director of Resident Services will conduct weekly calls with the RNC to review progress towards discharge of resident # 3, #4, #5.

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

- Divisionals have provided re-education and support to Director and RNC on methods to deal with residents/families on process for discharge of residents due to no longer meeting retention criteria.

The program will monitor performance to ensure compliance as follows:

- Divisional will audit resident records at least twice per year during onsite program visits and as needed to ensure residents remain appropriate for retention.

Date deficiencies corrected by: 05/5/18 and on-going