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 07/11/2018

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. Number of tenants without cognitive disorder: 27 Number of tenants with cognitive disorder: 14 TOTAL Census of Assisted Living Program: 41 This Program has met criteria to be an Assisted Living Program for People with Dementia by definition for the last two recertification visits. Investigation of Complaint #76253-C and Incident #76401-I resulted in regulatory insufficiencies.	A 000	See attached POC 8/7/18	
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. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans to reflect the identified needs of tenants. This pertained to 1 of 3 tenants reviewed (Tenant #2). Findings follow: 1. Record review on 7-10-18 of Tenant #2's file revealed Progress Notes indicated the following: a. On 6-30-18 at 2:30 p.m. it was noted a visitor	A 089		

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A 089	Continued From page 1 told staff Tenant #2 was on the ground outside (courtyard) laying on her left side in front of the porch swing. Tenant #2 had a bump on the top of the head. Family was contacted and requested an ambulance be called. A neurological check was not completed as Tenant #2 was unable to follow commands or open her eyes. An ambulance was called and Tenant #2 was taken to the hospital. b. On 7-5-18 at 10:15 a.m. it was noted at 7:10 a.m. Tenant #2 was found laying on the floor behind her door. She reported she bumped her head in the same spot as her fall on 6-30-18. No other injuries were noted and a neurological check was completed. Tenant #2 declined to be seen in the hospital or by a a doctor. c. On 7-5-18 at 1:30 p.m. it was noted a follow up assessment for the the fall that morning was completed. During the assessment it was observed her left pupil was slightly larger than the right and the grip in the left hand was much weaker than the right. Tenant #2 was transported to the emergency room (ER) via ambulance. d. On 7-5-18 at 6:30 p.m. Tenant #2 returned from the ER with family. A urine culture was pending and instructions included: to drink plenty of fluids and to continue with the antibiotic. Continued record review of Emergency Room Discharge Instructions dated 7-5-18 revealed the diagnoses included: a fall, dehydration and recurrent urinary tract infections (UTIs). Instructions included to drink plenty of fluids, to establish care with a local provider, continue taking the antibiotic that she currently took (amoxicillin 250 milligram twice per day) and the possibility of increased level of care.	A 089		

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A 089	Continued From page 2 Further record review revealed the service plan dated 6-15-18 reflected Tenant #2 was independent with toileting needs. The service plan reflected Tenant #2 had a history of falls and staff looked into her apartment once per night to ensure Tenant #2 was in bed and if she was up to assist her to the bathroom and back to bed. The service plan did not reflect Tenant #2 had recurrent UTIs and also did not provide additional interventions for falls during wake hours.	A 089		
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 interview and record review the Program failed to address issues with an electronic wandering monitoring system that was to provide an additional safety measure for those tenants with cognitive deficits. This affected 1 of 1 tenant reviewed that eloped (Tenant #1). It potentially affected all tenants who wore an electronic wandering monitoring device (15 tenants currently wore the device). Findings follow: 1. Record review on 7-10-18 of Tenant #1's file revealed a diagnosis of Alzheimer's dementia. Tenant #1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. The service plan dated 2-23-18 reflected Tenant #1 wore an electronic wandering	A 154		

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A 154	Continued From page 3	A 154		

monitoring device for safety. The service plan also indicated for staff to offer redirection if he was expressing any desire to leave, he often looked for his car or tried to get to his childhood home.

Continued record review revealed Progress Notes indicated on 2-22-18 at 5:45 p.m.staff responded to a page that Tenant #1 had exited through a door. Staff then paged staff in the front of the building to let them know he had gone out. Staff observed him out front and ran to the door to get him. Staff typed in the wrong code for the door alarm, which delayed staff getting outside. Staff watched him cross the street and then staff ran into the road to cross to the other side with him. Tenant #1 returned to the building with staff.

Further record review of an Incident Report dated 5-23-18 at 11:30 a.m. the Nurse returned to the building after taking another tenant to the doctor and was notified Tenant #1 was missing. Staff searched the interior and exterior of the building and surrounding neighborhoods. After the interior search was completed the Nurse dialed the phone to call Tenant #1's family and the police called. She hung up the phone with Tenant #1's family and answered the call from the police. They notified her Tenant #1 had been found in a parking lot of a local business. Tenant #1 had fallen, but did not have any injuries. Tenant #1's family was on the way to get him. The electronic wandering monitoring device system was reviewed and indicated Tenant #1 was missing from the living area at 10:31 a.m. An internal investigation was started.

When interviewed on 7-9-18 at 1:47 p.m. Staff A said she heard the pager go off at 11:05 a.m. to 11:10 a.m. (actual time) the pager had an

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A 154	Continued From page 4 incorrect time displayed of approximately 5:40 p.m. The page indicated Tenant #1 was missing (living room). The system should have alerted staff when Tenant #1 left the building and that page was not received. Staff A went to Staff C and she had not seen him. They checked his apartment and then notified Staff B. The Director and Nurse were notified by Staff B. Staff completed interior and exterior searches looking for Tenant #1. No door alarms went off and there were a lot of visitors in and out that morning. When interviewed on 7-9-18 at 2:36 p.m. Staff B said Staff A and Staff C asked if Staff B had seen Tenant #1 and the pager indicated he was missing. Staff B checked the computer and it indicated Tenant #1 was missing (living room). There were no alerts for the front door and there had not been any door alarms. Staff B informed the Director and the Nurse. Staff searched room to room and some staff searched outside of the building. A phone call was received from the police and Tenant #1 was found at a local business. Tenant #1 returned to the building later that day and had no recollection of what had occurred. Tenant #1 did not sustain any injuries. When interviewed on 7-10-18 at 3:26 p.m. Staff C said it was about lunch time and she received a page that indicated Tenant #1 was missing. Staff checked his apartment and he was not there. Staff B was made aware staff could not find Tenant #1 and Staff B checked the computer. Staff B notified the Director and a search started inside and outside the building. Some staff drove around in their cars looking for Tenant #1. There were no door alarms or other pages for Tenant #1 that morning.	A 154		

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A 154	Continued From page 5	A 154		

When interviewed on 7-10-18 at 9:11 a.m. Maintenance Staff said with the previous electronic wandering monitoring system (the system in place at the time of Tenant #1's elopement) had not worked correctly for about a year. There was a two to three minute delay to staff. The majority of the time it worked, and it responded all of the time; however, at times were was a delay to staff regarding notification of an alert.

When interviewed on 7-10-18 at 11:21 a.m. the Nurse said she had taken another tenant to a doctor appointment and upon return had assisted the other tenant with a shower. When she came out of that apartment Staff A informed her Tenant #1 was missing. Staff searched the interior and exterior of the building. The Nurse went to call Tenant #1's family, it was ringing and she saw on caller identification, the local police department calling. She hung up the phone and talked to the police who said Tenant #1 was found at a local business. The police reported Tenant #1's family was called and was on the way. Tenant #1 had fallen but did not sustain any injuries. Review of the system did not reveal when Tenant #1 exited the building there were no door alarms. Tenant #1 was gone at 10:30 a.m. and the police called at 11:30 a.m. The previous electronic wandering monitoring system (the system in place at the time of Tenant #1's elopement) had glitches in the system for the last six months that had been reported to branch support (corporate). There were delays on pagers to staff (30 seconds).

When interviewed on 7-10-18 at 11:02 a.m. and 1:53 p.m. the Director said Staff B reported the pager indicated Tenant #1 was missing. Staff started an interior and exterior search of the building. The computer indicated Tenant #1 was

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A 154	Continued From page 6	A 154		

missing; however, there was not a page for an exit door and there were no exit door alarms. The police called and reported Tenant #1 was found at a local business. Tenant #1's family was notified by police before staff at the Program. Tenant #1 returned to the Program and did not sustain any injuries. When Tenant #1 returned the electronic wandering monitoring device alarmed. Tenant #1's device was replaced and it was tested at each exit door. Branch support (corporate staff) was made aware of the issue and the Program was put to the top of the list for system replacement.

3. Record review revealed a report from the electronic wandering monitoring system printed on 5-24-18 revealed on 5-23-18 at 10:31 a.m. Tenant #1 was noted as missing (living room).

Continued Record review on 7-11-18 of electronic mail (e-mails) revealed there were e-mails from program staff to corporate staff regarding the issues with the electronic wandering monitoring system. The following emails were provided:

a. On 6-29-17 corporate staff was made aware by program staff of issues with the electronic wandering monitoring system. An unnamed tenant with a device walked out of the front entrance door on 6-29-17 behind a visitor. Staff saw the tenant walk out; however, the tenant's device did not go off. The tenant was outside for 15 minutes and the device never reported the tenant was missing. It had happened on three other occasions with random watches.

b. On 7-3-17 program staff told corporate staff the doors were checked every Friday with a different electronic monitoring device. The system was described as inconsistent, unreliable

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A 154	Continued From page 7 and a new system was needed. c. On 3-13-18 corporate staff was made aware by program staff of an issue with the electronic wandering monitoring system. A new staff was being trained and staff demonstrated how the door alarms worked. One of the tenant devices was taken to the front entrance door, the door was opened and the system did not alarm. The tenant device was taken to another exit door and the system went off immediately; however, it did not go to the pager until after they had reset the system and walked up to the nurse's station. Then a page was received that indicated the tenant was exiting by that exterior door. In summary, Tenant #1 wore an electronic wandering monitoring device for safety and had been identified as having exit seeking behavior. Tenant #1 had previously exited the building, in which he set off door alarms and exited on 2-22-18. On 5-23-18 staff received a page that Tenant #1 was missing. The electronic wandering monitoring system had not alerted staff when Tenant #1 exited or through which exit door Tenant #1 left the building. The first page staff received indicated Tenant #1 was missing. The alert on the computer regarding Tenant #1 missing was at 10:31 a.m.; however, staff reported not receiving the page that Tenant #1 missing until after 11:00 a.m. Tenant #1 eloped from the Program and traveled approximately 0.5 to 0.6 of a mile on a highly traveled street and in a area where construction was being completed. Tenant #1 was gone from the building for undetermined amount of time as there was not alert to document when Tenant #1 exited the building; however, the alert on the computer for Tenant #1 missing was at 10:31 a.m. the Nurse received the call from police at 11:30 a.m. Tenant	A 154		

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A 154	Continued From page 8 #1 had fallen (no injuries sustained) in the parking lot of a local business and police were called. The electronic wandering system in place at the time of Tenant #1's elopement had on-going issues and corporate staff was made of those issues dating back to 6-29-17. The system in place at the time of the Tenant #1's elopement failed to provide a safe environment to Tenant #1, including on 5-23-18, when he eloped. It also potentially failed to provide a safe environment for all tenants who wore the electronic wandering monitoring devices during the time period there were issues noted, from 6-29-17 until it was replaced nearly a year later, on 6-11-18 to 6-13-18.	A 154		

ok 8/10/18

Plan of Correction
Cedar Falls Bickford Cottage

A089 481-69.26(4)a Service Plans
Regulatory Insufficiency: Program failed to develop service plans to reflect the identified needs of tenants.

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

- Tenant #2 had evaluations completed on 7/27/18 that were used to update and individualize her Service Plan to appropriately reflect the resident's identified needs including recurrent UTI's and additional fall interventions.

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

- Divisional Director of Resident Service provided RNC re-education on Assessment Policy, Nurse Review Policy, Service Planning and Assessments Policy and Documentation Policy on 08/02/18.
- RNC will review Task Sheets, Incident/Accident Reports, Communication Book and observe residents for significant changes to identify the need for re-evaluations and Service Plan updates to reflect changes in the resident's identified needs.

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.

Date deficiencies corrected by: 08/07/18

A154 481-69.35(1)b Structural Requirements
Regulatory Insufficiency: Program failed to address issues with an electronic wandering monitoring system that was to provide an additional safety measure for those tenants with cognitive deficits.

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

- Tenant #1 electronic wandering monitoring device was replaced on 6/13/18 with the implementation of a new Quantum system.
- Those tenants' wearing an electronic wandering monitoring device received a replacement device on 6/13/18 with the implementation of the new Quantum system.

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

- New electronic wandering monitoring system installed by J & L on 6/11/18-6/13/18.
- J & L Quantum System representative provided education for all staff members on the new Electronic Monitoring System on 6/13/18.
- Director/RNC/Maintenance Director provided individual education on the new Electronic Monitoring System for those who could not attend the inservice on 6/13/18.

The program will monitor performance to ensure compliance as follows:

- Divisional will audit electronic wandering system at least twice per year during onsite program visits and as needed.

Date deficiencies corrected by: 08/07/18