4/22/19 OK 4/19/19

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
	S0023	A. BUILDING: _____ B. WING _____	02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE IOWA CITY	3500 LOWER W BRANCH RD IOWA CITY, IA 52245

(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: 28 Number of tenants with cognitive disorder: 7 TOTAL Census of Assisted Living Program: 35 This Program has met criteria to be an Assisted Living Program for People with Dementia by definition for the last two recertification visits. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for a Dementia Specific Assisted Living Program.	A 000	See attached POC 4/12/19	
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 that reflected the identified needs of the tenants. This pertained to 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Record review on 2-27-19 of Tenant #1's file	A 089		

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
	S0023	A. BUILDING: _____ B. WING _____	02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE IOWA CITY	3500 LOWER W BRANCH RD IOWA CITY, IA 52245

(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 089	Continued From page 1 revealed Progress Notes indicated the following: a. On 1-2-19 it was noted Tenant #1 was found sitting on the floor in front of the couch. Tenant #1 denied hitting her head and denied pain. b. On 1-3-19 it was noted Tenant #1 fell when other visitors/tenants passed her without any contact. No injuries were noted. c. On 1-5-19 it was noted Tenant #1 started on Levaquin 500 milligram (mg) by mouth for seven days. d. On 1-22-19 it was noted staff reported Tenant #1 had dark urine with a foul odor noted. Tenant #1 recently completed antibiotic therapy for a urinary tract infection (UTI). e. On 1-30-19 it was noted Tenant #1 was started on Augmentin 500 mg by mouth twice daily for seven days for a UTI. It was noted Tenant #1 had a history of UTIs. f. On 2-20-19 it was noted Tenant #1 fell and bled from the back of the head. Tenant #1 was transported to the hospital via ambulance and returned on 2-20-19. g. On 2-21-19 it was noted Tenant #1 fell on 2-20-19 and received five staples to the back of the head. Tenant #1 ambulated independently and had a history of falls. Tenant #1 had a walker and did not use it. Tenant #1 was issued another walker. Continued record review revealed the service plan dated 12-19-18 reflected Tenant #1 had a history of falls and if staff noticed Tenant #1 seemed weak or unsteady to offer to walk with	A 089		

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
	S0023	A. BUILDING: _____ B. WING _____	02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE IOWA CITY	3500 LOWER W BRANCH RD IOWA CITY, IA 52245

(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 089	Continued From page 2 her or to take a break. The service plan did not reflect Tenant #1 had a walker and did not use the walker. The service plan also did not reflect Tenant #1's history of UTIs and antibiotic therapy. 2. Record review on 2-27-19 of Tenant #2's file revealed Physician Orders's indicated the following: a. Refresh Tears drop 0.5%, instill one drop into each as needed for for dry eyes (wait 5 minutes between drops) was ordered dated 9-25-18. b. Eliquis 5 mg tablet, take one tablet by mouth twice daily was discontinued dated 1-18-19. Continued record review revealed the February 2019 medication administration records (MARs) reflected Refresh Tears eye drops were administered 20 times from 2-5-19 to 2-28-19. Further record review revealed the service plan dated 1-15-19 reflected Tenant #2 took Eliquis daily and to notify the Registered Nurse (RN) Coordinator of any blood in the urine, stools unusual bleeding or bleeding that would not stop. The service plan did not reflect the discontinuation of the anti-coagulant and did not reflect staff administered eye drops as needed. 3. Record review on 2-28-19 of Tenant #3's file revealed Progress Notes indicated the following: a. On 1-31-19 it was noted Tenant #3's family called and voiced concerns Tenant #3 would not take his medications. It was requested by family that medications be set up in a weekly planner and be monitored for compliance. Tenant #3 was	A 089		

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
	S0023	A. BUILDING: _____ B. WING _____	02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE IOWA CITY	3500 LOWER W BRANCH RD IOWA CITY, IA 52245

(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 089	Continued From page 3 agreeable to the plan and assistance, but wanted to independently take the medications. b. On 2-12-19 it was noted Tenant #3 complained of hearing voices and called a suicide line. Tenant #3 denied being suicidal and medications were removed from his apartment. Tenant #3 refused to go to the hospital for treatment. Tenant #3 denied suicidal ideations and visited with staff and other tenants. c. On 2-26-19 it was noted an outside agency nurse would be coming in to set up medications in a locked medication planner. Tenant #3 and his family requested Tenant #3 self-administered his medications. Tenant #3 denied suicidal ideations. Tenant #3 would continue to administer his medications with the outside agency nurse setting up medications. Tenant #3 reported he would report to staff if he was not able to administer his medications. Continued record review revealed the February 2019 MARs reflected staff administered as needed medications to Tenant #3 including: Acetaminophen 325 mg, take two tablets by mouth every four hours as needed for pain, Hydroxyzine HCL 25 mg, take one tablet by mouth every four hours as needed and Hydroxyzine HCL 25 mg take three tablets by mouth at bedtime as needed. Further record review revealed the service plan dated 12-27-18 reflected Tenant #3 administered his medications independently. The service plan was updated on 1-31-19 and reflected the RN Coordinator filled the medication planner weekly and monitored for compliance with taking medications. The service plan was updated on 2-26-19 and reflected an outside nursing agency	A 089		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0023	A. BUILDING: _____ B. WING _____	02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE IOWA CITY	3500 LOWER W BRANCH RD IOWA CITY, IA 52245

(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 089	Continued From page 4 set up the medications in the planner weekly and monitored. The service plan reflected the medication planner was set up weekly; however, did not address who administered the scheduled and as needed medications and the storage of the those medications. 4. Record review on 2-28-19 of Tenant #4's file revealed a fax to the physician indicated Tenant #4 had an increase in "hiding" food in napkins, moving food around on the plate and not eating as Tenant #4 was previously. Tenant #4 had a weight loss of 4.8 pounds that month and 13 pounds over the past six months. Orders were received dated 2-8-18 to continue Ensure three times daily as needed, continue to monitor weight and to work with Tenant #4 to complete meals if possible. Continued record review revealed the February 2019 MARs reflected Ensure, one can by mouth, three times per day as needed. It was documented as given 10 times between 2-13-19 and 2-27-19. The February MARs also reflected weekly weights were recorded. Further record review revealed the service plan dated 12-7-18, was updated on 2-7-19 and reflected staff was to offer ice cream in the evening and encourage Tenant #4 to eat. The service plan reflected Tenant #4 recently had weight loss; however, it did not reflect the nutritional supplement three times per day as needed. The service plan also did not reflect the weekly weights. 5. When interviewed on 2-28-19 at approximately 2:00 p.m. the RN Coordinator confirmed the	A 089		

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
	S0023	A. BUILDING: _____ B. WING _____	02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE IOWA CITY	3500 LOWER W BRANCH RD IOWA CITY, IA 52245

(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 089	Continued From page 5 above findings.	A 089		
A 104	481-69.28(5) Food Service 481-69.28(231C) Food service. 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff who served food had an orientation on safe food handling prior to serving food. This pertained to 2 of 7 staff reviewed (Staff A and D). Findings follow: 1. Record review of Staff A's file revealed a hire date of 5-25-18. Staff A had a training on food safety and sanitization; however, it was not completed until 11-15-18. 2. Record review of Staff D's file revealed a hire date of 9-5-18. Staff D had training on food safety and sanitation; however, it was not completed until 11-7-18. 3. When interviewed on 2-28-19 at 1:47 p.m. the Director revealed Staff A and D served food. The Director indicated with a change in administrative staff there were some training documents for some staff that could not be located and training was re-done to ensure it was completed.	A 104		

4/22/19 OK 4/19/19

Plan of Correction
Iowa City Bickford Cottage

A 089 481.69.26(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:

- Divisional Director of Resident Services provided the RNC education on Service Planning policy and development on 04/02/19.
- Resident #1 had evaluations completed and used to update and individualize their Service Plan to appropriately meet the resident's needs and preferences for assistance on 03/01/19.
- Resident #2 had evaluations completed and used to update and individualize their Service Plan to appropriately meet the resident's needs and preferences for assistance on 03/06/19 .
- Resident #3 had evaluations completed and used to update and individualize their Service Plan to appropriately meet the resident's needs and preferences for assistance on 03/06/19.
- Resident #4 had evaluations completed and used to update and individualize their Service Plan to appropriately meet the resident's needs and preferences for assistance on 04/03/19.

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

- RNC will review Task Sheets, Incident/Accident Reports, Communication Book, Progress Notes and observe residents for significant changes that trigger the initiation of evaluations and Service Plan updates in order to meet the resident's changing needs/preferences for care.

The program will monitor performance to ensure compliance as follows:

- Divisional will audit resident records at least twice per year during onsite program visits to determine Service Plans have been developed that meet the resident's current needs.

Date deficiencies corrected by: 04/12/19

A104 481-69.28(5)(231C) Food Service

Regulatory Insufficiency: Program failed to ensure staff who served food had an orientation on safe food handling prior to serving food.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Staff A had training on food safety and sanitation on 11-15-18.
- Staff D had training on food safety and sanitation on 11-7-18.

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

- Upon hire, new staff will participate in orientation on safe food handling prior to serving food.
- All staff serving food will participate in annual inservice education on safe food handling.

The program will monitor performance to ensure compliance as follows:

- Director will review new hire orientation documentation to ensure compliance with completion of safe food handling education prior to staff serving food.
- Director will monitor and assign annual inservice training for all staff serving food on safe food handling education and ensure compliance with completion.
- Divisional will audit staff records at least twice per year during onsite program visits and as needed.

Date deficiencies corrected by: 04/12/19