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
	S0009	A. BUILDING: _____ B. WING _____	12/12/2018

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: 21 Number of tenants with cognitive disorder: 2 Memory Care Unit Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 3 TOTAL Census of Assisted Living Program for People with Dementia: 28 The following regulatory insufficiency was cited during the recertification conducted to determine compliance with certification for an Assisted Living Program:	A 000	See attached POC 1/25/19	
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 interviews and record review the	A 089		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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
	S0009	A. BUILDING: _____ B. WING _____	12/12/2018

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 089	Continued From page 1 Program failed to consistently ensure service plans included identified needs and interventions to ensure tenant safety. This affected 1 of 3 tenants reviewed and 1 of 1 tenants reviewed residing in the memory care unit (Tenant #1). Finding follows: When interviewed on 12/10/18 at 1:50 p.m. Staff A expressed concern regarding Tenant #1's falls. She reported Tenant #1 would get up from where he sat and fall, sometimes while staff are assisted other tenants in their apartments. When interviewed on 12/10/18 at 2:35 p.m. Staff B expressed concern that Tenant #1 fell often and with one staff it was hard to assist other tenants and monitor him closely. Record review of Progress Notes on 12/11/18 revealed a notation for a Nurse review completed on 11/29/18 noted Tenant #1 had seven falls since the last assessment (10/9/18). Further review revealed incident reports recorded falls on the following dates: a. 10/7/18 at 1:45 p.m. b. 10/13/18 at 8:55 a.m. c. 10/21 18 at 4:20 p.m. d. 10/31/18 at 11:15 p.m. e. 11/4/18 at 3:15 p.m. f. 11/11/18 at 6:14 p.m. g. 11/26/18 at 12:35 p.m. Further review of incident reports noted two falls on 9/25/18 at 3:40 p.m. and 5:10 p.m. An additional incident report dated 12/1/18 described and incident where Tenant #1 sat in the recliner and became restless, started fidgeting around and flipped the recliner backwards.	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
	S0009	A. BUILDING: _____ B. WING _____	12/12/2018

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 089	Continued From page 2 When interviewed on 12/11/18 at 3:15 p.m. the Registered Nurse Coordinator (RNC) said the Program added the intervention of having the tenant spend time in the recliner in the common area to work on decreasing falls. When asked if that had been reflected in Tenant #1's service plan she said she thought so. After reviewing the service plan she admitted/confirmed the intervention had not been added to Tenant #1's service plan.	A 089		

OK
4/19/19

A089 481-69.26(4)a Service plans
Regulatory Insufficiency: Program failed to consistently ensure service plans included identified needs and interventions to ensure tenant safety.

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

- Tenants #1 no longer resides in the program.
- Divisional Director of Resident Service provided RNC re-education on Service Planning and Assessments Policy on 1/25/19.

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

- RNC will review Task Sheets, Incident/Accident Reports, Communication Book and observe residents for significant changes to initiate evaluations and Service Plan updates to meet resident's needs and interventions to ensure safety.

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: 01/25/19.