STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP020	A. BUILDING _____ B. WING _____	08/13/2019

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: 19 Number of tenants with cognitive disorder: 0 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 5 TOTAL Census of Assisted Living Program for People with Dementia: 24 The following regulatory insufficiencies were cited during the Investigation of Incident #84034-I.	A 000	See attached POC 9/27/19	
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to provide adequate and appropriate services to meet tenants' needs; specifically services identified in tenants' service plans. This affected 1 of 1 tenants reviewed as a result of Incident 84034-I (Tenant #1). Finding follows:	A 013		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 013	Continued From Page 1 Review of Tenant #1's file indicated he moved into the dementia unit on 3-18-19. Review of Cognitive Assessment completed 3-18-19 revealed a Global Deterioration Score of five, which indicated moderately severe cognitive decline. Review of Tenant #1's service plan, dated 3-18-19, revealed he required assistance for bathing, grooming, dressing, and redirection to time and place. Review of incident reports revealed a report dated 5-28-19 at 3:20 p.m., which documented Tenant #1 walked out of the dementia unit into the gated courtyard, opened the gate, and walked into the driveway. Staff responded to the alarm, observed him in the courtyard, and redirected him back inside. According to the state climatologist the weather on 5-28-18 at 3:15 p.m. in Muscatine was 64 degrees F with no heat index, relative humidity 82%, wind speed 9 miles per hour (mph) out of the north with peak gusts of 19 mph. On 8-13-19 at 1:34 p.m. Staff A stated she observed him walking into the courtyard and assumed Staff B had already gone outside. She stated Staff B returned and yelled that Tenant #1 was outside. Staff A followed her into the courtyard, and observed Tenant #1 opening the gate. She stated they redirected him back inside without incident. She confirmed she knew tenants required supervision when in the courtyard and failed to ensure Staff B was outside. On 8-13-19 at 3:00 p.m. Staff B stated she left the area to toilet a tenant and failed to inform Staff A she was leaving the area. She confirmed she received training that tenants required supervision when in the courtyard. She stated her pager alarmed when the courtyard door opened and	A 013		

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A 013	Continued From Page 2 assumed Staff A took someone outside. She stated she completed toileting when the pager alarmed for the gate and discovered Tenant #1 outside and redirected him inside without incident. On 8-13-19 at 10:22 a.m. the Registered Nurse Coordinator stated Staff A and Staff B received formal counseling when the failed to provide supervision to a tenant in the courtyard. She stated all staff received training that tenants required supervision if they go to the courtyard.	A 013		
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 an individualized service plan according to tenants' identified needs. This affected 1 of 1 tenants reviewed as a result of Incident 84034-I (Tenant #1). Finding follows: Review of Tenant #1's file indicated he moved into the dementia unit on 3-18-19. Review of Cognitive Assessment completed 3-18-19 revealed a Global Deterioration Score of five, which indicated moderately severe cognitive decline. Review of Tenant #1's service plan dated 3-18-19 revealed he required assistance for bathing, grooming, dressing, and redirection to time and place. Review of Incident Report dated 4-9-19 at 5:30	A 089		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 089	Continued From Page 3 p.m. Tenant #1 walked out of the dementia unit into the gated courtyard, opened the gate, and walked into the driveway. Staff responded to the alarm, observed him in the courtyard, and redirected him back inside. Review of Incident Report dated 5-28-19 at 3:20 p.m. Tenant #1 walked out of the dementia unit into the gated courtyard, opened the gate, and walked into the driveway. Staff responded to the alarm, observed him in the courtyard, and redirected him back inside. On 8-13-19 at 1:34 p.m. Staff A confirmed Tenant #1 exhibited exit seeking behavior prior to 5-28-19 elopement. On 8-13-19 at 10:22 a.m. the Registered Nurse Coordinator confirmed she failed to update his service plan after his first elopement to reflect exit seeking behavior and interventions to minimize them.	A 089		

OK 10/21/19

10/21/19

Plan of Correction
Muscatine Bickford Cottage

A 013—481-67.3(2) Tenant Rights
Regulatory Insufficiency: Program failed to provide adequate and appropriate services to meet tenants' needs; specifically, services identified in tenants' service plans.

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

- RNC completed a Nursing Assessment, Service Assessment, Cognitive Assessment and a Service Plan update for Tenant #1 on 5/31/19 and 7/16/19.

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

- Divisional Director of Resident Services provided re-education to the Director and RNC on Resident Bill of Rights and Service Planning and Agreement Policy on 09/23/19.
- Director/Designee will re-educate all staff members on the Resident Bill of Rights and Service Planning and Agreement Policy on 09/26/19. Those staff who are not in attendance shall be provided 1:1 education.
- Upon hire, the Director/Designee will provide education to new staff members on Resident Bill of Rights and Service Planning and Agreement Policy.

The program will monitor performance to ensure compliance as follows:

- Divisional Director will audit tenant Service Plans and care delivery to ensure adequate and appropriate services are provided to meet tenant's needs as identified in the tenants' service plan twice per year during onsite visits.

Date deficiencies corrected by: 09/27/19

A089 481-69.26(4)a Service plans
Regulatory Insufficiency: Program failed to develop an individualized service plan according to tenants' identified needs.

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

- RNC completed a Nursing Assessment, Service Assessment, Cognitive Assessment and a Service Plan update for Tenant #1 on 5/31/19 and 7/16/19.

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

- Divisional Director of Resident Services provided re-education to the Director and RNC on Resident Bill of Rights and Service Planning and Agreement Policy on 09/23/19.

- 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 tenant's individualized needs.

The program will monitor performance to ensure compliance as follows:

- Divisional Director will audit tenant Service Plans and care delivery to ensure adequate and appropriate services are provided to meet tenant's needs as identified in the tenants' service plan twice per year during onsite visits.

Date deficiencies corrected by: 09/27/19.