OK 11/24/2020 ✓2/3/20

PRINTED: 10/29/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP018	A. BUILDING _____ B. WING _____	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CLINTON	1150 13TH AVE N CLINTON, IA 52732

(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. Number of tenants without cognitive disorder: 33 Number of tenants with cognitive disorder: 5 Total number of Tenants in ALP/D: 38 The following regulatory insufficiencies were cited during the investigation of #83996-I	A 000	See attached POC 11/13/19	
A 008	481-67.2(1)e Program Policies and Procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. This Requirement is not met as evidenced by: Based on interview and record review, the program failed to immediately record incidents for 1 of 1 tenants (Tenant #1). Findings follow. Record review revealed Tenant #1 admitted to the	A 008		

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

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A 008	Continued From Page 1 program on 3/21/19. Continued review of incident reports revealed the following: a. A report dated, "7/1/19 for 3/22/19" documented Tenant #1 awake through the night and attempting to leave until about 3:30 a.m. Tenant #1 set off door alarms and went into other tenants rooms. She was redirected each time. b. A report dated, "7/1/19 for 3/26/19" documented Tenant #1 soiled with bowel movement. Staff took her to the restroom to assist her. When staff pulled Tenant #1's pants down, she began to resist and swung to hit staff. Staff backed away, told her her pants were wet and needed changed. Tenant #1 continued to refuse and staff went to get additional staff to assist. c. A reported dated, "7/1/19 for 4/13/19" documented Tenant #1 soiled her bed and depends. When staff attempted to assist her and Tenant #1 became combative when staff began to pull her pants down. Tenant #1 got up and walked to the bathroom after several attempts by staff. Staff told Tenant #1 she would pull her pants down to assist her. As staff began to pull Tenant #1's pants down, Tenant #1 became very upset and attempted to hit staff. d. A report dated, "7/1/19 for 4/17/19" documented Tenant #1 became aggressive while toileting and preparing for bed. Tenant #1 slapped staff in the head when she attempted to remove Tenant #1's pants. e. A report dated, "7/1/19 for 4/20/19" documented staff approached Tenant #1 to assist with using the restroom, due to her soiling herself. Tenant #1 became combative as soon as her pants were pulled down. Tenant #1 scratched staff, hit, squeezed staff skin and would not let go,	A 008		

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A 008	Continued From Page 2 kicked staff in the stomach, and name called. f. A report dated, "7/1/19 for 5/3/19" documented staff received a call from another staff requesting assistince. When staff entered the apartment, Tenant #1 stood in the bathroom and swung at, hit, and attempted to bite staff. Staff assisted the other staff to remove Tenant #1's soiled pants. Staff reassured Tenant #1 that staff were just helping her clean up. Tenant #1 continued to scratch, attempt to bite, and hit. g. A report dated, "7/1/19 for 5/5/19" documented Tenant #1 grabbed staff's hair and would not release, as staff assisted her to dress. Once Tenant #1 released staff's hair, she continued to be combative until cares were complete. h. A report dated, "71/19 for 5/9/19" documented Tenant #1 became aggressive as two staff assisted her to toilet. Tenant #1 needed to be cleaned up and as staff attempted to do so, Tenant #1 bit staff's left ear. The Program's Incident and Accident Report policy directed, "Incidents or accidents are to be reported and documented immediately after they occur". During an interview with the Director on 9/11/19 at 4:40 p.m., she stated she learned staff members documented unusual occurrences for Tenant #1 in the progress notes and not on Incident Reports around 7/1/19. At that time, Incident Reports were written to correct the mistake.	A 008		
A 085	481-69.26(3) Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care	A 085		

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A 085	Continued From Page 3 or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. This Requirement is not met as evidenced by: Based on interview and record review, the program failed to update a service plan with a significant change for 1 of 1 tenant (Tenant #1). Findings follow: Record review on 9/11/19 revealed Tenant #1 was admitted to the program on 3/21/19. Tenant #1 had diagnoses including was diagnosed with dementia, hypertension, anxiety, agitation, chronic Urinary Tract Infection, hyperlipidemia and arthritis. Tenant #1 had a Service Plan dated 4/17/19 which identified she benefited from simple, one step directions. The service plan noted Tenant #1 became anxious when staff would attempt to remove her clothing so they were to explain step by step during the entire process. Tenant #1 had episodes of swatting at others but was generally easily re-directed with speaking to her in a calm, soft voice and talking to her about her family or Elvis. It was noted Tenant #1 did best when she was allowed to wake up on her own in the morning. A review of Incident Reports revealed: - On 4/17/19 at 11:00 PM, Tenant #1 became aggressive when staff was taking her to the bathroom and helping her prepare for bed. When staff was removing Tenant #1's pants, Tenant #1 slapped the staff person in the head. - On 4/18/19 at 7:15 AM, two staff members were trying to provide incontinence care to Tenant #1 and she became angry, punching one staff	A 085		

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A 085	Continued From Page 4 member in the stomach seven times and then in the chest three times. - On 4/20/19 at 4:30 AM, staff approached Tenant #1 to provide incontinence care as she was soiled with bowel movement. Tenant #1 became combative as soon as staff attempted to remove her pants. Tenant #1 was scratching, hitting, squeezing staff's skin, and kicked them in the stomach. - On 4/22/19 at 7:30 AM, two staff members attempted to change Tenant #1's soiled brief. Tenant #1 began choking one staff member and slapping another in the face. She punched them two times. Tenant #1 also bit one staff person on the shoulder. - On 5/3/19 at 8:30 PM, one staff member called for assistance when providing cares to Tenant #1. Tenant #1 was hitting, scratching, and attempting to bite staff while the other staff was attempting to change her soiled incontinence brief. - On 5/5/19 at 9:00 AM, Tenant #1 grabbed a staff member's hair when she was trying to dress the tenant. - On 5/6/19 at 6:15 AM, staff went in to get Tenant #1 up for the day. Tenant #1 got upset and started kicking the staff member. The staff member sought help and Tenant #1 slapped and dug her nails into the second staff member. - On 5/6/19 at 10:45 AM, staff went into Tenant #1's apartment and Tenant #1 kicked, slapped and tried to bite staff on the shoulder. - On 5/7/19 at 5:00 AM, staff provided incontinence care to Tenant #1 as she was soiled with bowel movement. Tenant #1 became aggressive and bit a staff member's ear. - On 5/7/19 at 6:30 AM, staff went to Tenant #1's room to get her up and dressed for the day. They found her incontinence brief was soiled. Tenant #1 began biting, kicking, punching and scratching staff. - On 5/9/19 at 8:40 AM, staff provided toileting	A 085		

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A 085	Continued From Page 5 assistance to Tenant #1 as her incontinence brief was soiled with bowel movement. Tenant #1 bit a staff member's ear. - On 5/9/19 at 10:00 AM, a staff member had tried three times to take Tenant #1 to the bathroom and the tenant batted at her. On the fourth attempt, Tenant #1 did let the staff member take her to the toilet. - On 6/16/19 at 4:30 AM staff was providing incontinence care to Tenant #1. Tenant #1 started to scratch, bite, pinch and put her teeth on the staff member. - On 6/25/19 at 5:30 AM, it was noted Tenant #1 had been wandering into other residents' apartments. Tenant #1 was wearing only an incontinence brief and an unbuttoned shirt. Tenant #1 was becoming increasingly aggressive and was slapping staffs' arms leaving bruising. Tenant #1 tripped and fell, resulting in a fractured right mandible. Tenant #1's service plan was not updated until 6/25/19. On 9/12/19 at 9:00 AM, the Director confirmed the Program failed to update Tenant #1's service plan in a timely manner after a significant change in tenant behavior.	A 085		

Plan of Correction
Bickford Cottage Clinton

✓ 2/3/20

A008 481-67.2(1)e Program Policies and Procedures.
Regulatory Insufficiency: The program failed to immediately record incidents for tenant #1.

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

- Resident #1 no longer resides at Bickford as of 08/08/2019.

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

- Divisional Director of Resident Services will provide re-education on 10/31/19 to the Director and RNC on the Incident/Accident Report Policy.
- The RNC will provide education to new staff members, upon hire, on the Incident/Accident Report Policy.
- RNC will re-educate all staff members on Incident/Accident Report Policy on 11/06/2019. Those staff who are not in attendance shall be provided 1:1 education.

The program will monitor performance to ensure compliance as follows:

- The Director and RNC will review all Incident Report documentation to ensure that program staff properly complied with Incident/Accident Report Policy.
- Director and/or RNC will provide individual education or counseling for staff members who are not compliant with following appropriate policy guidelines.
- Divisional will audit resident records twice per year during onsite visits. To ensure that incidents have been properly documented.

Date deficiencies corrected by: 11/13/2019.

A085 481-69.26 (3) Service Plans.
Regulatory Insufficiency: The program failed to update a service plan with a significant change for Tenant #1.

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

- Resident #1 no longer lives at Bickford as of 08/08/2019.

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

- Divisional Director of Resident Services will provide RNC re-education on Service Planning and Assessments Policy on 10/31/2019.
- RNC will review Task Sheets, Incident/Accident Reports 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: 11/13/2019.