

✓ 5/14/20 OK 5/14/20

PRINTED: 04/27/2020
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IAALPD004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER BICKFORD COTTAGE MARION			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 LINDEN DR MARION, IA 52302		
(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: 31 Number of tenants with cognitive disorder: 1 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 6 TOTAL Census of Assisted Living Program for People with Dementia: 38 The following regulatory insufficiencies were cited during the investigation of Complaint #87457-C, Incident #88018-I and the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program:	A 000	See attached DOC 5/12/20		
A 012	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to ensure tenants were treated with consideration, respect, and full recognition of personal dignity and autonomy. This pertained to 8 of 38 tenants (Tenants #1, #2, #7, #8, #9, #10, #11 and #12). Findings follow:	A 012			

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

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A 012	Continued From Page 1 1. Record review revealed the Program's internal investigation included an Investigation Form-General, dated 1-7-20. The form indicated on the afternoon of 1-7-20, Staff L brought allegations of abuse by Staff M and Staff N to the attention of management. The investigation was completed 1-7-20 - 1-10-20 and Staff M and Staff N were suspended pending the investigation. The Program's investigation included an interview with Staff L, completed 1-7-20, which summarized the allegations brought forth. Staff L reported she and Tenant #1's spouse were getting Tenant #1 up and the spouse mentioned something about Tenant #1 being scared of third shift. The spouse said Tenant #1 told her that third shift was irritated, rude and mean to him regarding asking for help. Tenant #1 consistently told the spouse and she saw how scared he was. She thought something happened. Staff L told Tenant #1's spouse he had confided in her over the past three weeks too. There had been more than a couple of times someone said they would be right there over the intercom and he looked at this clock and it took over an hour or no one ever came. Tenant #1 expressed that he was "scared to death to go to bed and pull the cord." Every time Tenant #1 told Staff L about the concerns Staff M and Staff N had worked the prior night and she saw a pattern. Staff L also reported Tenant #9 had said that he did not like Staff M and Staff N and they were not "very nice to him." It was more Staff N than Staff M. Staff L also reported Staff N made remarks about Tenant #1 and made fun of him for drinking alcohol. When interviewed on 1-21-20 at 3:27 p.m. Staff L revealed Tenant #1 was a newer tenant (first week of December). During conversation in the second to third weeks of December the tenant mentioned some things he though concerning. During the first conversation he said two "big men" came in	A 012		

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A 012	Continued From Page 2 and were rough with him at night. There were no men that worked the night shift but she let him continue with the story. Tenant #1 brought it up again and again, a handful of times. During that time Staff L tried to determine if Tenant #1 hallucinated or if he was coming to her with something. He would tell her he was afraid to pull the call cord at night and would ask if she remembered what they had talked about. Tenant #1 did not allege physical abuse. He reported he starred at the clock by his bed and waited an hour for assistance. Tenant #1's concerns were always regarding night shift. When Tenant #1's spouse was in the apartment she said something to Staff L when she was helped. The things Tenant #1 mentioned to Staff L over the weeks he had told his spouse too and it was a consistent story. It included staff being impatient and getting irritated. The next day she spoke to the Nurse and Director. When interviewed on 1-22-20 at approximately 2:30 p.m. Tenant #1 revealed he was afraid to go to bed at night and described it as harassment. He said it was very difficult to sleep with one eye open and one eye closed. He was not comfortable with they were going to do. After he pulled his cord he waited for an hour. They intimidated him and possibly others. He said there were no concerns now. When interviewed on 1-22-20 at 11:55 a.m. Tenant #1's spouse revealed Tenant #1 felt harassed and intimidated by the night shift and kept repeating it. It was almost immediately after he came in he started reported and she thought maybe he dreamt it. She went to the Nurse and Director and asked to talk to them. Things had improved at night. There were no other complaints regarding different shifts or time of day. Tenant #1's spouse visited daily and was there for about 90% of the day.	A 012		

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A 012	Continued From Page 3 When interviewed on 1-21-20 at 4:25 p.m. Staff D reported she also had concerns regarding Staff N's interactions with tenants. Staff D recalled she left a note for the Nurse on 12-20-19 regarding Tenant #8. Staff D and Staff N were in the office and Tenant #8 came out and staff got her hot chocolate. When Staff D was giving report to Staff N Tenant #8 started visited with staff. Staff N shooed her away and said goodnight and go to bed towards Tenant #8, three to five times. Tenant #8 walked away and had a frown on her face. She also said approximately a year ago, Tenant #9 was not wearing his hearing aides and he kept asking if she was Staff N. Staff D said yes and he grabbed the toilet paper. He said they made him do it at night, regarding wiping himself. Staff D said staff was supposed to assist Tenant #9. When interviewed on 1-15-20 at 10:53 a.m. and 1-22-20 at 11:08 a.m. Staff G recalled her shift had ended on the weekend and she came up the hall from the memory care unit and heard yelling "get back to bed" and "stay there." At first she did not know what was going on and when she got to the nurse's station she realized Staff M and Staff N were yelling at Tenant #7 and #10. Staff N grabbed Tenant #10's hand and took her to the apartment. Staff G described it as aggressive. Tenant #10 had just walked up to the common area. Staff M yelled at Tenant #7. Tenant #7 had been asleep in the common area. Tenant #7 was annoyed to have to go back to his apartment. It was described that Staff M was annoyed and rude but was not as aggressive as Staff N. She said she called for transfer assistance for Tenant #2 at approximately 5:30 a.m. to 6:00 a.m. Staff M and Staff N came back to help and were aggressive towards Tenant #2. Tenant #2 was transferred from her bed to the wheelchair, from the	A 012		

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A 012	Continued From Page 4 wheelchair to the toilet and back to the wheelchair with Staff G and Staff M, one on each side. Staff N helped with the wheelchair. To keep Tenant #2 from sitting in mid air, Staff N pushed her to keep her up and pushed on her mid back. Staff M yelled for Tenant #2 to stand up and keep standing and yanked her up. Staff G tried to use a soft voice. One night she walked up from the the memory care unit at the end of her shift. She heard people yelling. When she got close to the office she realized it was Staff N yelling at Tenant #10 to go to bed, and why was she up. Staff N took Tenant #10 by the hand to her apartment. When that was going Staff M raised her voice at Tenant #7 to go bed when he was "clearly comfortable sleeping on the couch." Staff M and Staff N had told Staff G that Tenant #1 was "such a pain the butt" and "he's always calling for no reason" and "I'm not going in there anymore." When interviewed on 1-22-20 at 12:31 p.m. Staff F revealed she gave Tenant #12 a shower and was half way done with the shower when Staff N came in and interrupted Tenant #12 and Staff F and Staff N would shush Tenant #12. That same night/day as the shower, Tenant #12 was confused and needed to go to the bathroom Staff M and Staff N started laughing at Tenant #12. When interviewed on 1-23-20 at 11:26 a.m. Staff M revealed she was suspended for allegation of abuse. She said regarding Tenant #1's pull cord that there were times he had the cord wrapped around his finger and it was pulled so hard it almost was pulled out of the wall. Tenant #1 had fallen one time on third shift and there was alcohol in the apartment. When Tenant #1 drank alcohol he was more difficult to transfer. She said Staff G, Staff M and Staff N were present for Tenant #2's transfer. Staff G and Staff M assisted Tenant #2 off of the bed into the wheelchair and then Staff N	A 012			

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A 012	Continued From Page 5 wheeled her into the bathroom. Tenant #2 was transferred from the wheelchair to the toilet with Staff G and Staff M assisting. Staff G got Tenant #2 dressed on the toilet. There were three to four attempts to transfer Tenant #2 back into the wheelchair. Regarding if there was anything rough or aggressive with the transfer Staff M said the way that Staff G pushed her shoulder into Tenant #2's back. She said it was all that staff could do at that point. Staff M denied yelling or raising her voice at tenants. The Program's interview document dated 1-9-20 and Staff N's statement dated 1-9-20 indicated Staff N said on 12-23-19 Tenant #1 fell in his apartment and there was a bottle of alcohol on the floor. Tenant #1's apartment was in "disarray." Another night he pulled his cord, Staff M and Staff N were each on a side and he could not lift his head or speak. When they put his bed up he had purple liquid on his shirt and bed. She said "oh you're kidding me" when she found a bottle of wine. When Tenant #7 was out in the living room at night, staff woke him up and took him back to his apartment. When asked why Tenant #7 would be woken up if sleeping soundly, Staff N said they did not wake him up if sleeping soundly but at times his neck looked uncomfortable. Staff N denied assisting with Tenant #2 and the transfer on 1-4-20. Staff N indicated she did not feel any of the allegations against her were true. Staff N denied raising her voice or telling a tenant to be quiet. Staff N was hard of hearing and indicated her voice at times was loud but she tried to be mindful when she spoke. She did not assist with lifting a tenant in the memory care unit due to a staff member not trusting her lifting. She had concerns regarding a change in a tenant's behavior and the consumption of alcohol.	A 012			

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A 012	Continued From Page 6 When interviewed on 1-22-20 at 3:21 p.m. and on 1-23-20 at approximately 9:45 a.m. the Director revealed Staff L had reported over time Tenant #1 had expressed being fearful at night and it followed a pattern. Tenant #1's spouse had also brought similar concerns. Staff L reported Tenant #1 said it took over hour to help when the pull cord was used, when staff came they were rude and they stood over him, which created fear. Tenant #1 did not want to ask for help. A pattern was noted when Staff M and Staff N worked. It was determined Staff M and Staff N would be suspended. She completed interviews with staff and additional allegations regarding different tenants came out in staff interviews. Most staff were fearful to come forward. She also interviewed Tenant #1 and his spouse. Staff M denied the allegations; however, said Staff N did raise her voice. Staff N denied the allegations. Staff N was terminated on 1-14-20 including for tenant rights violation. 3. Continued record review revealed the Program's Resident Bill of Rights indicated the Program was a housing alternative that promoted tenant rights and freedom of choice for all decisions that did not adversely effect the Program. All tenants had the right to be treated with consideration, respect and full recognition of personal dignity and autonomy.	A 012		
A 039	481-69.23(1)b Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance	A 039		

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A 039	Continued From Page 7 with standing, transfer or evacuation This Requirement is not met as evidenced by: Based on observation, interview and record review the Program failed to discharge a tenant who required a routine two-person assist with transfers. This pertained to 1 of 6 tenants reviewed (Tenant #2). Findings follow: Observation on 1-21-20 at approximately 1:35 p.m. revealed Tenant #2 transferred from her wheelchair to stand to grab the bar in the bathroom. It took two attempts to get Tenant #2 to stand from the wheelchair with two staff and a gait belt. Two staff also assisted Tenant #2 with a transfer from the wheelchair to the recliner. A gait belt was utilized in that transfer. When interviewed on 1-15-20 at 3:30 p.m. Staff C reported approximately 80% of the time Tenant #2 took two staff to transfer and she took three staff to transfer 10% of the time and one staff to transfer 10% of the time. When interviewed on 1-15-20 at 10:53 a.m. Staff G reported Tenant #2 required a routine two person assist and exceeded the level of care. Staff G said most of the time Tenant #2 took three staff to transfer; however, at a minimum she took two staff for transfers. Tenant #2 had needed a two person assist for four months. When interviewed on 1-15-20 at 10:26 a.m. Staff H said Tenant #2 was a routine two person assist and exceeded the level of care. Two staff were used for safety for Tenant #2 for at least a month. When interviewed on 1-15-20 at 1:16 p.m. Staff I said 90% or more of the time two or three staff were used for safety with Tenant #2's transfers. Last week when Staff I assisted with her transfers		A 039		

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A 039	Continued From Page 8 the day prior and two staff were used. When interviewed on 1-15-20 at 1:58 p.m. Staff J said Tenant #2 was a two person transfer 100% of the time and 70 to 80% of the time three to four staff were used for transfers. Tenant #2 had been a two person transfer for months. When interviewed on 1-15-20 at approximately 3:00 to 3:30 p.m. Staff K said Tenant #2 usually took at least two people to transfer. Tenant #2 suddenly decided to sit (during transfers) and was not walking anymore. Two or three staff were used for her transfers and one person could not do it. Three people were used to transfer Tenant #2 50% of the time now. Record review on 1-21-20 of Tenant #2's file revealed diagnoses included: age related osteoporosis with current pathological fracture, muscle weakness, obesity, spinal stenosis and abnormalities of gait and mobility. Tenant #2 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant #2 resided in the memory care unit. Continued record review revealed the service plan dated 1-20-20 reflected Tenant #2 required the assistance of one to two staff with transfers and use of a gait belt. Tenant #2 stood for a short period of time with her walker in front of her. Tenant #2 tended to want to sit down quickly and staff was to be aware of that. Tenant #2 was occasionally able to take a step or two. Tenant #2 used a wheelchair with staff assist. Tenant #2 had a history of falls. Further record review revealed Progress Notes dated 1-20-20 indicated Tenant #2 used one to two staff for transfers. Tenant #2 was at times	A 039			

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A 039	Continued From Page 9 combative and the service plan would be updated with interventions. Due to increased cares the Nurse had spoke with Tenant #2's family about a possible discharge related to the level of care. The last service plan updated prior to 1-20-20 was on 8-27-19. When interviewed on 1-22-20 at 3:21 p.m. the Director said she had helped transfer Tenant #2 last week and it took three staff, one to assist with perineal care and two to transfer. For safety, two staff were being used for Tenant #2 more than 50% of the time. There had been a discussion regarding level of care for Tenant #2 with family and family was agreeable; however, wanted to keep Tenant #2 there. Service plan and medication lists were sent to a another facility for potential placement. In summary, Tenant #2 was exceeding the level of care, as a routine two person assist with transfers. There had been a discussion with Tenant #2's family regarding level of care; however, Tenant #2 had been exceeding the level of care for possibly an extended time period. There was not nothing documented in Tenant #2's file regarding expected transfer or discussions with the family regarding the need for transfer with the exception of the Progress Note dated 1-20-20. Additionally, the service plan updated on 1-20-20 did not reflect Tenant #2 current transfer needs (see section 481-69.26(231C) Service plans.)	A 039		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the	A 083		

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A 083	Continued From Page 10 specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This Requirement is not met as evidenced by: Based on observation, interview and record review the Program failed to update service plans as needed and failed to ensure service plans reflected the identified needs of the tenants. This pertained to 5 of 6 tenants reviewed (Tenants #2, #3, #4, #5 and #6). Findings follow: 1. Record review on 1-21-20 of Tenant #2's file revealed diagnoses included age related osteoporosis with current pathological fracture, muscle weakness, obesity, spinal stenosis and abnormalities of gait and mobility. Tenant #2 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant #2 resided in the memory care unit. When observed on 1-21-20 at approximately 1:35 p.m. Tenant #2 transferred from her wheelchair to stand to grab the bar in the toilet. It took two attempts to get Tenant #2 to stand from the wheelchair with two staff and a gait belt. Two staff also assisted Tenant #2 with a transfer from the wheelchair to the recliner. A gait belt was utilized in that transfer. Continued record review revealed the service plan dated 1-20-20 reflected Tenant #2 required the assistance of one to two staff with transfers and use of a gait belt. Tenant #2 stood for a short	A 083		

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A 083	Continued From Page 11 period of time with her walker in front of her. Tenant #2 tended to want to sit down quickly and staff was to be aware of that. Tenant #2 was occasionally able to take a step or two. Tenant #2 used a wheelchair with staff assist. Tenant #2 had a history of falls. The last service plan updated prior to 1-20-20 was on 8-27-19. Tenant #2's service plan was not updated as needed and did not reflect the service needs of Tenant #2. When interviewed on 1-15-20 at 3:30 p.m. Staff C reported 80% of the time Tenant #2 took two staff to transfer and she took three staff to transfer 10% of the time and one staff to transfer 10% of the time. When interviewed on 1-15-20 at 10:53 a.m. Staff G reported Tenant #2 required a routine two person assist and exceeded the level of care. Staff G said most of the time Tenant #2 took three staff to transfer; however, at a minimum she took two staff for transfers. Tenant #2 needed a two person assist consistently for four months. When interviewed on 1-15-20 at 10:26 a.m. Staff H said Tenant #2 was a routine two person assist and exceeded the level of care. Two staff were used for safety for Tenant #2 for at least a month. When interviewed on 1-15-20 at 1:16 p.m. Staff I said 90% or more of the time two or three staff were used for safety with Tenant #2's transfers. Last week when Staff I assisted with her transfers it was from the bed to the wheelchair and two staff were used. When interviewed on 1-15-20 at 1:58 p.m. said Tenant #2 was a two person transfer 100% of the time and 70 to 80% of the time three to four staff were used for transfers. Tenant #2 had been a two person transfer for months.	A 083			

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A 083	Continued From Page 12 When interviewed on 1-15-20 at approximately 3:00 to 3:30 p.m. Staff K said Tenant #2 usually took at least two people to transfer. Tenant #2 suddenly decided to sit (during transfers) and was not walking anymore. Two or three staff were used for her transfers and one person could not do it. Three people were used to transfer Tenant #2 50% of the time now. When interviewed on 1-22-20 at 3:21 p.m. the Director said she had helped transfer Tenant #2 last week and it took three staff, one to assist with perineal care and two to transfer. For safety, two staff were being used for Tenant #2 more than 50% of the time. There had been a discussion regarding level of care for Tenant #2 with family and family was agreeable; however, wanted to keep Tenant #2 there. Service plan and medication lists were sent to a another facility for potential placement. 2. Record review on 1-21-20 of Tenant #3's file revealed his diagnoses included polymyalgia rheumatica and dementia. Tenant #3 was staged at a three on the GDS, which indicated mild cognitive decline. Continued record review revealed Progress Notes documented the following: a. On 10-14-19 Tenant #3 slapped another tenant in the face. There were no injuries noted and family took Tenant #3 to the emergency room (ER). b. On 10-18-19 Tenant #3 returned from the hospital with a medication change. c. On 10-23-19 it was noted on the evening of	A 083		

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A 083	Continued From Page 13 10-22-19 Tenant #3 had an increase in aggressive behaviors. Family was notified and transported her to the ER. d. On 11-14-19 it was noted Tenant #3 returned to the Program on 11-13-19. e. On 11-20-19 Tenant #3 talked to another tenant and began to pass out. The other tenant called for help and when staff arrived she was leaning on the other tenant's walker but was not on the floor. During lunch Tenant #3 had another episode similar to the morning. Family was notified and took Tenant #3 to the ER. She returned on 11-20-19 with no new orders. f. On 12-13-19 it was noted Tenant #3 went to an urgent care clinic on 12-12-19 for pain/swelling in the toe/leg. Tenant #3 returned with an order a new order for aspirin 325 milligram (mg) every day. g. On 12-15-19 it was noted Tenant #3 went to an urgent care clinic again for the same issue with the left foot. A new order was received for Cephalexin 5 mg, three times daily for 10 days and Lotrimin cream, apply three times daily every for 14 days and Nitroglycerin ointment 0.4% ointment apply pea size amount to the left fourth toe every day for 14 days. h. On 12-18-19 it was noted Tenant #3 had a follow up appointment with her primary care provider and it was determined it was cellulitis of the 4th toe. Epsom salt soaks (15 minutes) daily for two weeks were added. i. On 1-20-20 it was noted staff reported as needed medications for agitation had not been very effective. Tenant #3 remained agitated for awhile after as needed medication was given	A 083			

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A 083	Continued From Page 14 Continued record review revealed the service plan dated 11-18-19 reflected Tenant #3 was hospitalized from 10-23-19 to 11-14-19 for behaviors and medications were changed, which had helped Tenant #3. The service plan failed to reflect the behaviors noted and interventions, the episodes that occurred on 11-20-19 or the cellulitis and treatment. 3. Record review on 1-22-20 revealed Tenant #4's file indicated a diagnosis of dementia. Tenant #4 was staged at a four on the GDS, which indicated moderate cognitive decline. Tenant #4 resided in the memory care unit. When observed on 1-23-20 Tenant #4 transferred with two staff out of the wheelchair and into bed. When interviewed on 1-15-20 at 3:30 p.m. Staff C said staff used two people for transfers with toileting for Tenant #4. When interviewed on 1-15-20 at 10:26 a.m. Staff H said two people were used for transfers at least 50% of the time. When interviewed on 1-15-20 at 1:58 p.m. Staff J said some staff changed Tenant #4 in bed for toileting due to transfers. When interviewed on 1-15-20 at approximately 3:00 p.m. to 3:30 p.m. Staff K said with toileting two staff assisted Tenant #4. For toileting one staff assisted with cares and one with the transfer. With Tenant #4 it was dependent on the transfer. Most people could transfer Tenant #4 with one. When interviewed on 1-22-20 at 3:21 p.m. the Director said with toileting a second person was	A 083		

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A 083	Continued From Page 15 used for perineal care and safety. The majority of the time staff could transfer her with one person. It was not routine and was less than 50%. Continued review of Progress Notes indicated the following: a. On 9-20-19 it was noted Tenant #4 had an open area to the right outer ankle. b. On 9-25-19 it was noted a return fax was received for Tegaderm to area, change every 72 hours and to cushion the ankle when sitting if possible. c. On 11-8-19 it was noted a return fax was received to start Kelfex 500 mg three times daily for 10 days. It was in response to the fax about the area on the ankle not healing with just the dressing changes. d. On 11-25-19 it was noted the area on the ankle was healed. Review of January 2020 MARs revealed an order to apply Tegaderm foam 4 x 4 pads to the affected area of the ankle every 72 hours. It was documented as completed every 72 hours. Further record review revealed Tenant #4's service plan dated 11-4-19 reflected Tenant #4 used a wheelchair for mobility. Staff was to assist with all transfers. If Tenant #4 ambulated a short distance staff was to attempt to have Tenant #4 use her walker and provide assistance. The service plan also reflected staff would assist her with toileting due to her cognition and would complete perineal cares if she was incontinent. The service plan failed to reflect at times, including with toileting, Tenant #4 required two staff to assist and if toileting cares occurred in	A 083			

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A 083	Continued From Page 16 bed. The service plan dated 11-4-19 reflected Tenant #4 received a treatment to the right ankle per physician's orders. The service plan did not reflect the status of Tenant #4's ankle as the Progress Notes indicated it was healed and staff continued to apply the dressing change. 4. Record review of Tenant #5's file revealed diagnoses included: a dog bite, traumatic open wound to of the right leg, dementia and depression. Tenant #5 was staged at a three on the GDS, which indicated mild cognitive decline. Continued record review revealed Tenant #5's Progress Notes indicated the following: a. On 11-25-19 it was noted that on 11-23-19 Tenant #5 pushed through a group of visitors and left from the front door. A staff was with her at all times. While outside Tenant #5 hit, kicked and screamed. The local police department was called for assistance. They directed her inside the building; however, her behaviors continued. Tenant #5 was sent to the ER for evaluation. Tenant #5 returned later via ambulance. b. On 11-27-19 it was noted Tenant #5 was very agitated that morning, pushed on doors and yelled. The wound nurse was there and was not able to change the dressing due to Tenant #5's agitation. c. On 12-4-19 it was noted Tenant #5 had a follow up at the wound clinic and the left arm was healed. The right leg continued with dressing changes twice daily. d. On 12-18-19 it was noted Tenant #5 was seen at the wound clinic and no changes were made to the dressing changes. It was added tubigrip over	A 083		

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A 083	Continued From Page 17 the dressing. Continued record review revealed the service plan 11-18-19 revealed Tenant #5 had been bitten by a dog (prior to coming to the Program) and had stitches to the right arm and dressings to the left arm. Tenant #5 had areas on her legs from the dog bites but did not have any dressing changes to those areas. A home health nurse would be completing dressing changes, typically three times per week. The service plan reflected Tenant #5 often asked when she was going home and why she was there. Tenant #5 had times she had become upset and agitated. The service plan did not reflect the healing of the left arm and dressing change to the right leg and tubigrip. The service plan also did not reflect Tenant #5 pushed through a group of visitors and left building (staff was with her at all times) and the police were called to redirect. 5. Record review on 1-22-20 of Tenant #6's file revealed diagnoses included: dementia, depression and anxiety. Observation on 1-22-20 at approximately 12:50 p.m. revealed Tenant #6 sat in a wheelchair at the dining room table after lunch. When interviewed on 1-15-20 at 1:16 p.m. Staff I said two staff assisted with toileting with Tenant #6. One staff would hold Tenant #6 up and one staff would assist with cares. Staff I said Tenant #6 could ambulate with her walker in the apartment and a wheelchair was used to come out to the dining room. If walking in the apartment, one staff assisted. When interviewed on 1-22-20 at 4:19 p.m. the Nurse revealed a wheelchair was typically used for	A 083		

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A 083	Continued From Page 18 when Tenant #6 was outside of the apartment. In her apartment Tenant #6 ambulated with a walker and stand by assistance. When interviewed on 1-22-20 at 3:21 p.m. the Director said Tenant #6 had a decline recently and had a urinary tract infection. With toileting assist two people were used. From chair to chair one person was used for transfers. Tenant #6 had used the wheelchair recently. The service plan dated 11-27-19 reflected Tenant #6 was independent with ambulation and used a walker for mobility. The service plan did not reflect Tenant #6's transfer and mobility needs. 6. When interviewed on 1-22-20 at 4:19 p.m. the Nurse revealed all current service plans were provided for the tenants listed above. When interviewed on 1-22-20 at 3:21 p.m. the Director revealed all current service plans were provided for the tenants listed above.	A 083		
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 sanitation and safe food	A 104		

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A 104	Continued From Page 19 handling prior to handling food and an annual in-service training on food protection. This pertained to 3 of 8 staff reviewed (Staff B, D and E). Findings follow: 1. Record review on 1-14-20 and 1-15-20 revealed Staff B's training documents indicated a hire date of 9-4-19. Staff B received training on food safety and sanitation; however, it was dated 11-21-19, which was greater than two months after hire. 2. Record review on 1-14-20 and 1-15-20 revealed Staff D's training documents indicated a hire date of 2-12-19. Staff D received training on food safety and sanitation; however, it was dated 4-17-19; which was greater than two months after hire. 3. Record review on 1-14-20 and 1-15-20 of Staff E's training documents revealed a hire date of 12-23-16 and a transfer date of 6-4-18. Staff E did not have an annual in-service on training and food protection completed in 2019. The most recent food safety and sanitation training was dated 10-11-18. 4. When interviewed on 1-22-20 at 3:18 p.m. the Director revealed Staff B, C and E all served food and all food safety training documents were provided for the staff listed above.	A 104			
A 121	481-69.30(1) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of	A 121			

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A 121	Continued From Page 20 dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to ensure all staff employed by the Program completed eight hours of dementia-specific education and training within 30 days of employment. This pertained to 2 of 8 staff reviewed (Staff A and Staff B). Findings follow: 1. Record review on 1-14-20 and 1-15-20 revealed Staff A's training documents indicated a hire date of 9-9-19. Continued review failed to produce documentation Staff A received eight hours of dementia-specific education within 30 days of employment. 2. Record review on 1-14-20 and 1-15-20 of Staff B's training documents revealed a hire date of 9-4-19. Continued review failed to produce documentation Staff B received eight hours of dementia-specific education completed within 30 days of employment. 3. When interviewed on 1-23-20 at the exit meeting the Director revealed all the dementia specific education for Staff A and Staff B were provided.	A 121			
A 147	481-67.5(6)d Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: d. Medications shall be administered as	A 147			

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A 147	Continued From Page 22 medication administration records (MARs) revealed the following: -Acetaminophen tablet 500 milligram (mg), take one tablet by mouth, three times daily for pain was documented as not given from 12-6-19 to 12-27-19 at 2:00 p.m. The MAR indicated the medication was not available to administer. -Vitamin B Complex, take one capsule by mouth, daily was documented as not given from 12-7-19 to 12-31-19. The MAR indicated the medication was not available to administer. -Melatonin Max 5 mg tablet, take one tablet by mouth at bedtime for insomnia, was documented as not given from 12-6-19 to 12-26-19. The MAR indicated the medication was not available to administer. -Preservision Areds two capsules, take one capsule by mouth, twice daily, was documented as not given from 12-6-19 to 12-26-19. The MAR indicated the medication was not available to administer. -Vitamin D3, 2000 units, take one tablet by mouth, daily, was documented as not given from 12-7-19 to 12-31-19. The MAR indicated the medication was not available to administer. When interviewed on 1-21-20 at approximately 10:35 a.m. the Nurse revealed there had been no adverse outcome related to the medications not administered for Tenant #1. The medications were not brought in by Tenant #1's family. After that time Tenant #1 was signed up with the Program's pharmacy. In summary, Tenant #1 had medications administered by the Program. From the time of	A 147		

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A 147	Continued From Page 23 Tenant #1's admission to the end of December 2019 medications that were physician ordered were not administered as prescribed. There was no documentation found in Tenant #1's file regarding notification to Tenant #1's physician related to the medications not administered as prescribed.	A 147			

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A 147	Continued From Page 21 prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to administer medications as prescribed by the tenant's physician. This pertained to 1 of 6 tenants reviewed (Tenant #1). Findings follow: 1. Record review on 1-14-20 and 1-15-20 of Tenant #1's file revealed diagnoses included: Parkinson's disease, major depressive disorder, muscle weakness, hypertension and heart disease. Tenant #1 was staged at a three on the Global Deterioration Scale, which indicated mild cognitive decline and was admitted on 12-6-19. Tenant #1's the service plans dated 12-4-19 and 1-3-20 reflected staff administered Tenant #1's medications. Continued record review revealed Physician Orders reflected the following orders: -Acetaminophen tablet 500 milligram (mg), take one tablet by mouth, three times daily for pain. -B Complex, take one capsule by mouth, daily. -Melatonin Max 5 mg tablet, take one tablet by mouth at bedtime for insomnia. -Preservision Areds two capsules, take one capsule by mouth, twice daily. -Vitamin D3, 2000 units, take one tablet by mouth, daily. Further record review indicated December 2019	A 147		

OK
5/14/20

**Plan of Correction
Marion Bickford Cottage**

A012 481-67.3(1) Tenant Rights

Regulatory Insufficiency: Program failed to ensure tenants were treated with consideration, respect, and full recognition of personal dignity and autonomy.

Plan of Correction:

The insufficiencies will be corrected as follows:

- RN Coordinator performed a Nursing Assessment, Cognitive Assessment, Service Assessment and service plan for Tenant #1 on 4/2/2020. RNC directs/delegates resident care per physician order.
- Tenant #2 was discharged from the program on 1/29/2020.
- RN Coordinator performed a Nursing Assessment, Cognitive Assessment, Service Assessment and service plan for Tenant #7 on 2/12/2020. RNC directs/delegates resident care per physician order.
- RN Coordinator performed a Nursing Assessment, Cognitive Assessment, Service Assessment and service plan for Tenant #8 on 3/10/2020. RNC directs/delegates resident care per physician order.
- Tenant #9 no longer resides at Bickford as of 2/28/2020.
- RN Coordinator performed a Nursing Assessment, Cognitive Assessment, Service Assessment and service plan for Tenant #10 on 3/20/2020. RNC directs/delegates resident care per physician order.
- Tenant #11 is not noted in the state report.
- RN Coordinator performed a Nursing Assessment, Cognitive Assessment, Service Assessment and service plan for Tenant #12 on 4/9/2020. RNC directs/delegates resident care per physician order.
- Director/RNC or designee will provide re-education to Staff G, Staff D, Staff L, Staff M and Staff F on Resident Bill of Rights beginning 5/12/2020 as they begin their work day.
- Staff N was terminated on 1/14/2020.

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

- Divisional Director of Resident Services provided re-education on 5/11/2020 to the Director and RNC on Resident Bill of Rights.
- Upon hire, the Director/RNC or Designee will provide education to new staff members on Resident Bill of Rights.
- Director/RNC or Designee will provide all staff members re-education on Resident Bill of Rights. This education will begin 5/12/2020 and be provided as each BFM begins his/her shift.

The program will monitor performance to ensure compliance as follows:

- The RNC will interview residents during the assessment process regarding any concerns/issues and report to the Director for Investigation and follow up.

Date deficiencies corrected by: 05/12/2020.

A039 481-69.23(1)b Criteria for Admission/Retention of Tenants

Regulatory Insufficiency: Programed failed to discharge a tenant who required a routine two-person assist with transfers.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #2 no longer lives at Bickford as of 1/29/2020.

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

- Divisional Director of Resident Services provided re-education on 5/11/2020 to the Director and RNC on Criteria for Admission and Retention.
- Upon hire, the Director/RNC or Designee will provide education to new staff members on Criteria for Admission and Retention.
- Director/RNC or Designee will provide all staff members re-education on Criteria for Admission and Retention. This education will begin 5/12/2020 and be provided as each BFM begins his/her shift.
- RNC will assess all residents prior to move in and as needed to ensure residents remain appropriate and meet admission and retention criteria.
- Divisional Director of Resident Services will review twice per month all residents requiring assistance of two to determine retention criteria are met.

The program will monitor performance to ensure compliance as follows:

- Divisional Director or Designee will audit resident records at least twice per year during onsite program visits and as needed.

Date deficiencies corrected by: 05/12/2020.

A083 481-69.26(1) Service Plans

Regulatory Insufficiency: Programed failed to update service plans as needed and failed to ensure service plans reflected the identified needs of the tenants.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #2 was discharged from the program on 1/29/2020.
- RN Coordinator performed a Nursing Assessment, Cognitive Assessment, Service Assessment and service plan for Tenant #3 on 2/14/2020. RNC directs/delegates resident care per physician order.

- RN Coordinator performed a Nursing Assessment, Cognitive Assessment, Service Assessment and service plan for Tenant #4 on 5/1/2020. RNC directs/delegates resident care per physician order.
- RN Coordinator performed a Nursing Assessment, Cognitive Assessment, Service Assessment and service plan for Tenant #5 on 3/19/2020. RNC directs/delegates resident care per physician order.
- RN Coordinator performed a Nursing Assessment, Cognitive Assessment, Service Assessment and service plan for Tenant #6 on 2/24/2020. RNC directs/delegates resident care per physician order.
- Divisional Director or Resident Services provided re-education to the RNC on Service Plan Policy on 5/11/2020.

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

- RNC will review Communication Book and observe residents for significant changes to initiate evaluations and Service Plan updates to meet resident's individual needs and preferences for care.

The program will monitor performance to ensure compliance as follows:

- Divisional Director or Resident Services or Designee will audit resident records at least twice per year during onsite program visits and as needed to ensure resident Service Plans reflect identified needs of the tenants.

Date deficiencies corrected by: 05/12/2020.

A104 481-69.28(5) Food Service

Regulatory Insufficiency: Program failed to ensure staff who served food had an orientation on sanitation and safe food handling prior to handling food and an annual in-service training on food protection.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Staff B had training on food safety and sanitation on 11/21/2019.
- Staff D had training on food safety and sanitation on 4/17/2019 and 4/6/2020.
- Staff E had training on food safety and sanitation in West Des Moines Bickford on 12/13/2016, 2/28/2017 and 2/28/2018 and in Marion Bickford 4/6/2020.

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 Director or Operations will audit staff records at least twice per year during onsite program visits and as needed.

Date deficiencies corrected by: 05/12/2020.

A121 481-69.30(1) Dementia Specific Education for Personnel

Regulatory Insufficiency: Program failed to ensure all staff employed by the program completed eight hours of dementia-specific education and training within 30 days of employment.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Staff A is no longer employed.
- Staff B completed a minimum of eight hours of dementia specific education on 11/19/2019.

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

- Upon hire, new staff will receive a minimum of eight hours of dementia specific education and training within 30 days of employment or beginning date of contract.

The program will monitor performance to ensure compliance as follows:

- Director will review new hire orientation documentation to ensure compliance with completion of at least eight hours of dementia specific education within 30 days of employment or beginning date of contract.
- Divisional Director of Operations will audit staff records at least twice per year during onsite program visits and as needed.

Date deficiencies corrected by: 05/12/2020.

A147 481-67.5(6)d Medications

Regulatory Insufficiency: Program failed to administer medications as prescribed by the tenant's physician.

Plan of Correction:

The insufficiencies will be corrected as follows:

- RN Coordinator performed a Nursing Assessment, Cognitive Assessment, Service Assessment and service plan for Tenant #1 on 4/2/2020. RNC directs/delegates resident care per physician order.

- Divisional Director or Resident Services provided re-education to the RNC on Medication Administration Policy on 5/11/2020.

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

- RNC will monitor each resident's physician orders and medication administration ensuring orders are current and that medications are administered per orders.

The program will monitor performance to ensure compliance as follows:

- Divisional Director or Resident Services or Designee will audit resident records at least twice per year during onsite program visits and as needed to ensure the program administers medications as prescribed by the tenant's physician.

Date deficiencies corrected by: 05/12/2020.