STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP028	A. BUILDING _____ B. WING _____	12/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE DAVENPORT	4040 E 55TH ST DAVENPORT, IA 52806

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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: 25 Number of tenants with cognitive disorder: 4 TOTAL Census of Assisted Living Program for People with Dementia: 29 The investigation of Incident #89498-M resulted in the following regulatory insufficiencies:	A 000	See attached POC 2/22/21	
A 003	481-67.2 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. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to consistently follow established policies and procedures. This pertained to 2 of 2 tenants reviewed . Findings follow: The Program self-reported an allegation of a	A 003		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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A 003	Continued From Page 1 medication diversion from tenants, including medications for Tenant #1. 1. Record review revealed a typed statement signed by the Former RN Coordinator indicated medications were received from pharmacy via a delivery service on 2-11-20. The received medications included three bubble pack cards of Tramadol 50 milligram (mg) for Tenant #1, both scheduled and as needed (PRN) doses, for a total of 120 tablets. The Former RN Coordinator questioned the delivery of the as needed Tramadol bubble pack card (60 tablets) as Tenant #1 did not currently use the as needed Tramadol. It was determined every time the scheduled Tramadol (twice daily) was re-ordered monthly, the PRN Tramadol (twice daily as needed) was automatically sent. According to the statement, Staff B recalled receiving three Tramadol bubble pack cards the month prior for Tenant #1 and said the cards were put in the medication cart. The medication cart was searched and Tenant #1's PRN Tramadol bubble pack card from the month prior was not located. Staff B said she had not given Tenant #1 PRN Tramadol. The Former RN Coordinator took a picture of the new PRN Tramadol bubble pack card before shift change with Staff B present and it was placed in the medication cart. Shift change occurred and a narcotic count was completed between Staff B and Staff A. The only staff with access to the medications after that time were the Former RN Coordinator, the Assistant Director, Staff A and Staff C. The Former RN Coordinator arrived at 5:00 a.m. on 2-12-20 and the entire PRN Tramadol bubble pack card for Tenant #1 was missing. She interviewed Staff C and she had not given PRN Tramadol to Tenant #1. The Former RN Coordinator asked Staff C to write a statement. Staff A was scheduled to work on second shift that day and would be interviewed at	A 003		

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A 003	Continued From Page 2	A 003		

that time.

A typed statement signed by the Former RN Coordinator and Assistant Director indicated Staff A was interviewed on 2-12-20 by the Former RN Coordinator and Assistant Director. Staff A allegedly admitted to taking medications from tenants, including Tenant #1. Staff A allegedly admitted to taking Tenant #1's Tramadol PRN bubble pack the evening prior and reported she had the bubble pack card in her car. After the interview Staff A was walked to her car by the Former RN Coordinator and Tenant #1's PRN Tramadol bubble pack card was retrieved from her car. There were 10 tablets missing from the bubble pack card.

Continued record review of Tenant #1's February 2020 medication administration records (MARs) indicated orders for Tramadol HCL 50 mg one tablet twice daily as needed for pain and Tramadol HCL 50 mg one tablet, twice daily at 8:00 a.m. and 8:00 p.m. The MARs reflected no PRN doses documented as administered in February 2020. The MARs indicated the last scheduled dose of Tramadol 50 mg was given on 2-11-20 at 8:00 p.m. The morning dose was not administered on 2-12-20 as Tenant #1 could no longer drink water or swallow. Tenant #1 died on 2-23-20.

The Pharmacy Return policy indicated controlled medications could not be returned. Pharmacy Packing Slip records revealed 120 tablets of Tramadol for Tenant #1 were received on 2-11-20.

The Med Disposition Log for Tenant #1 from 11-1-19 to 2-29-20 did not reflect the destruction of any Tramadol tablets in the timeframe provided.

Further record review of the Program's Medication Disposal policy and procedure indicated the

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A 003	Continued From Page 3 disposal of medications was recorded on the drug disposal form and included the following: the name, the reason, the method and signature of the staff that disposed of the medication. Controlled medications were disposed of by the the RN Coordinator and another licensed person. The drug disposal form indicated the method used and both people that witnessed the disposal signed. When interviewed on 11-3-20 at 4:13 p.m. the Director confirmed there was no destruction records found for the Tramadol tablets for Tenant #1. In summary, On 2-11-20, 120 tablets of Tramadol were received from pharmacy for Tenant #1. There were no as needed Tramadol doses documented as given in February 2020. The scheduled Tramadol doses (twice daily) were only documented as given through 2-11-20. Tenant #1's as needed Tramadol bubble pack with 10 tablets missing was allegedly retrieved from Staff A's car on 2-12-20. There was no documentation of the destruction of the Tenant #1's Tramadol tablets, both scheduled and as needed tablets, per the Program's policy and procedure. 2. Record review revealed a typed statement signed by the Former RN Coordinator indicated medications were received from pharmacy via a delivery service on 2-11-20. The received medications included three bubble pack cards of Tramadol 50 milligram (mg) for Tenant #1, both scheduled and as needed (PRN) doses, for a total of 120 tablets. The Former RN Coordinator questioned the delivery of the as needed Tramadol bubble pack card (60 tablets) as Tenant #1 did not currently use the as needed Tramadol.	A 003		

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A 003	Continued From Page 4 It was determined every time the scheduled Tramadol (twice daily) was re-ordered monthly, the PRN Tramadol (twice daily as needed) was automatically sent. According to the statement, Staff B recalled receiving three Tramadol bubble pack cards the month prior for Tenant #1 and said the cards were put in the medication cart. The medication cart was searched and Tenant #1's PRN Tramadol bubble pack card from the month prior was not located. Staff B said she had not given Tenant #1 PRN Tramadol. The Former RN Coordinator took a picture of the new PRN Tramadol bubble pack card before shift change with Staff B present and it was placed in the medication cart. Shift change occurred and a narcotic count was completed between Staff B and Staff A. The only staff with access to the medications after that time were the Former RN Coordinator, the Assistant Director, Staff A and Staff C. The Former RN Coordinator arrived at 5:00 a.m. on 2-12-20 and the entire PRN Tramadol bubble pack card for Tenant #1 was missing. She interviewed Staff C and she had not given PRN Tramadol to Tenant #1. The Former RN Coordinator asked Staff C to write a statement. Staff A was scheduled to work on second shift that day and would be interviewed at that time. A typed statement signed by the Former RN Coordinator and Assistant Director indicated Staff A was interviewed on 2-12-20 by the Former RN Coordinator and Assistant Director. Staff A allegedly admitted to taking medications from tenants, including Tenant #1. Staff A allegedly admitted to taking Tenant #1's Tramadol PRN bubble pack the evening prior and reported she had the bubble pack card in her car. After the interview Staff A was walked to her car by the Former RN Coordinator and Tenant #1's PRN Tramadol bubble pack card was retrieved from her	A 003		

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A 003	Continued From Page 5 car. There were 10 tablets missing from the bubble pack card. When interviewed on 10-26-20 at 12:30 p.m. Staff B revealed the Former RN Coordinator requested she write a statement (related to the investigation). When interviewed on 10-29-20 at 8:00 a.m. Staff C revealed was asked to write a statement (related to the investigation). Continued record review revealed an incident report dated 2-12-20, which indicated it had been initiated for a medication diversion. The report further referenced attached investigative documents. However, no documents were available for review. Further record review of the Program's Abuse and Neglect policy and procedure indicated if the Director or healthcare professionals believed a tenant had been abused, neglected or exploited it was reported immediately to the state and to corporate. If any staff believed a tenant had been abused, neglected or exploited it was immediately reported to the Director or RN Coordinator. A report would include: "Any additional information that might be helpful in the investigation of the allegation and protection of the Resident(s)." An internal investigation would be completed and documented on the Investigative Report document. When interviewed on 11-3-20 at 4:13 p.m. the Director confirmed the staff statements for Staff B and C were not found and there were no pictures found related to the investigation. In summary, the Program self-reported an allegation of a medication diversion for tenants, including Tenants #1 and #2. Investigation	A 003		

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A 003	Continued From Page 6 documents were requested related to the allegation including: direct care staff statements and pictures. The requested items were not found and could not be provided. The Program did not follow their policy regarding Abuse and Neglect regarding the collection and documentation of investigative information related to the allegation.	A 003		
A 057	481-67.9(3) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(3) Training documentation. The program shall have training records and staffing schedules on file and shall maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to maintain documentation of nurse delegated tasks. This pertained to 1 of 1 staff reviewed (Staff A). Findings follow: 1. Record review on 11-2-20 and 11-4-20 revealed Staff A, a certified medication aide, was hired at another branch within the same corporation on 10-30-17 and then transferred to Program (continuously employed) on 6-14-18. When requested, nurse delegation documents for Staff A could not be located. 2. When interviewed on 11-3-20 at 9:14 a.m. and 4:13 p.m. the Director confirmed nurse delegations were not found for Staff A. The Director said the nurse delegation documents	A 057		

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A 057	Continued From Page 7 were kept in a binder that had been taken out of the building by Staff A and were not returned.	A 057		

Plan of Correction
Davenport Bickford Cottage

A 003- 481-67.2 Program Policies and Procedures
Regulatory Insufficiency: Program failed to consistently follow established policies and procedures.

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

- Bickford will follow the Medication Management Policy related to medication destruction and Abuse/Neglect Policy related to documentation regarding an investigation of allegations of resident rights.
- Tenants #1 no longer resides in the program.

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 new RNC on the Medication Management Policy and Abuse/Neglect Policy on 2-11-21.
- The Director/RNC will provide education to new staff members, upon hire, on Medication Management Policy and Abuse/Neglect Policy.
- Director/RNC re-educated all staff members on Medication Management Policy and Abuse/Neglect Policy on 2-12-21. Those staff who were not in attendance shall be provided 1:1 education or Self Study.

The program will monitor performance to ensure compliance as follows:

- Divisional will audit resident incidents and medication destruction records at least twice per year during onsite visits and as needed to ensure that the facility has followed Medication Management and Abuse/Neglect Policies.

Date deficiencies corrected by: 2-22-21

A 057—481-67.9(3) Staffing:
Regulatory Insufficiency: The Program failed to maintain documentation of nurse delegated tasks.

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

- Staff A is no longer employed by Bickford of Davenport.

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

- Divisional Director of Resident Services provided education on 2-11-21 to the Director and new RNC on the Nurse Delegation Policy.

The program will monitor performance to ensure compliance as follows:

- Divisional Director will audit staff delegation files through quality audits annually to ensure compliance with nurse delegation documentation.

Date deficiencies corrected by: 2-22-21