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
	S0024	A. BUILDING: _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

(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 impairment: 23 Number of tenants with cognitive impairment: 14 Total census: 37 No regulatory insufficiencies were cited during the investigation of Mandatory Report #118579-M, Incident #115002-I and Complaint #116715-C. The following regulatory insufficiencies were cited during the investigation of Incident #119906-I and Complaint #116015.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, staff failed to follow established policies regarding medication administration. This affected 1 of 4 tenants reviewed (Tenant #1). Findings include: On 4/30/24 a review of Tenant #1's record revealed an admission date of 8/2/23. Tenant #1's record contained an internal investigation dated 3/29/24. The internal investigation revealed Staff E reported to administration that Staff F observed Staff H attempt to give Tenant #1 four 325mg	A 150		

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

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A 150	Continued From page 1	A 150		

Tylenol tablets at one time at approximately 7:30 pm on 3/28/24. Tenant #1 refused the four tablets. Upon intervention by Staff E, it was discovered Staff H attempted to make up for a missed administration of two 325mg Tylenol tablets at 2:00 pm. Staff H stated she attempted to give four Tylenol tablets to Tenant #1 to avoid receiving a medication error. Two Tylenol tablets were destroyed by Staff E and Tenant #1 received the the correct amount of two tablets of Tylenol. Administration initiated an investigation.

After staff statements were received, it was discovered another similar medication error incident occurred on 3/7/24. The Director received information that revealed Staff E, Staff F and Staff G observed Staff H attempt to give Tenant #1 medications for 3 separate medication passes at one time. Tenant #1 refused to swallow the medications and screamed with the pills in her mouth. Staff H stated to Staff E, Staff F and Staff G she had neglected to complete a 4:00 pm med pass for Tenant #1 on 3/6/24 and a 4:00 pm med pass on 3/7/24 so she was administering the meds from those missed passes with the medications for the current med pass. Tenant #1 was given the correct number of tablets by Staff E after all of the pills were removed from her mouth.

When interviewed on 4/29/24 at 4:16 pm, Staff G stated Staff H asked if she could go to Tenant #1's room with her to administer Tenant #1's 8:00 pm medications. She assumed Staff H believed she needed help. Tenant #1 was asleep lying flat on her bed. Staff H woke Tenant #1 up, but she was not very coherent as her eyes were still closed. Staff H dumped the medications in her mouth. Tenant #1 screamed because she had not wanted to swallow the pills. Staff G retrieved Staff E. Staff E arrived and was confused by all the

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A 150	Continued From page 2	A 150		

medications in Tenant #1's mouth. She fished them out with her fingers. Staff E asked Staff H why there were two extra magnesium tablets in the medications. Staff H stated she missed administering the tenant's 4 pm medications both earlier that day (3/7/24) as well as the day prior (3/6/24). She did not want to get a medication error so she gave all of the medication passes at one time. Staff E flushed the extra medications in the toilet and gave Tenant #1 the correct 8 pm medications. The staff involved had not told administration about the incident because they believed it was a waste of time so they did not do anything at the time. Staff G stated they had told administration about other things Staff H had done wrong but nothing was done about it. Later in the month on 3/29/24, nursing approached Staff G and Staff E about a separate incident Staff H had and that is when they told them about the incident on 3/7/24.

On 4/29/24 at 3:56 pm, Staff E stated she was in a tenant's room between 7:00 and 7:30 pm on 3/27/24 when Staff G arrived and stated Tenant #1 was choking. When she got to the room, Tenant #1 was lying flat on her back and her mouth was wide open. Staff E stated there were a lot of large pills in Tenant #1's mouth. Tenant #1 appeared sleepy. Staff E stated she put on gloves and dug the pills out of Tenant #1's mouth. She noticed there were 4 magnesium tablets in the pills she extracted from Tenant #1's mouth and questioned Staff H. Staff H stated she had forgotten to administer the 4 pm magnesium tablets on 3/6/24 and the magnesium tablets at 4 pm on 3/7/24 so she put those medications into the cup with the 8 pm medications on 3/7/24. Staff E told Staff H that was not how that worked. Staff H stated it was fine because they were just vitamins. Staff E flushed the magnesium in the

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A 150	Continued From page 3	A 150		

toilet and administered the correct 8 pm medications to Tenant #1. Staff E stated she nor Staff G told administration about the incident as they had told administration things Staff H had done wrong in the past and nothing was done about it. Staff E stated they later told administration about the 3/7/24 incident when there was an investigation regarding the 3/28/24 incident involving Staff H.

On 4/30/24 record review revealed the following physician orders:
- On 3/6/24 between 4 pm to 6 pm Tenant #1 should have Magnesium 64 SR, 2 tablets by mouth.
- On 3/7/24 between 4 pm to 6 pm Tenant #1 should have Magnesium 64 SR, 2 tablets by mouth.
- On 3/7/24 between 7 pm and 9 pm Tenant #1 should have Cyclobenzapr 10 mg 1 tablet by mouth, Divalproex 500 mg ER 2 tablets by mouth, Mirtazapine 30 mg 1 tablet by mouth, and Senna-Plus 8.6-50 mg 1 tablet by mouth.

Review of the Program's Medication Administration policy revealed if a medication error occurred, staff should notify the Registered Nurse Coordinator (RNC), the tenant involved, the tenant's enacted power of attorney (POA), and the healthcare provider. Staff involved in the incident had not contacted the appropriate people after the incident occurred. Administration had not learned of the 3/7/24 incident until a second incident occurred on 3/28/24.

On 5/1/24 at 1:38 pm, the Director and Registered Nurse Coordinator confirmed the above findings.

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A 330	Continued From page 4	A 330		
A 330	481-69.25(1)q Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs) This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to document all personal cares on daily task sheets for 1 of 4 tenants reviewed (Tenant #1). Findings include: On 4/30/24, a review of Tenant #1's record revealed an admission date of 8/2/23. The record contained hospice paperwork which revealed Tenant #1 was admitted to hospice on 3/15/24. The tenant's service plan dated 3/18/24 revealed services staff provided on including assistance with AM dressing, assistance with PM undressing and preparation for bed, emptying the catheter bag 2 to 3 times daily, assistance with peri-cares, and round checks during the night time hours. Tenant #1's record lacked task sheets that documented the personal cares provided by staff members. On 5/1/24 at 1:38 pm, the Director and Registered Nurse Coordinator confirmed the above findings.	A 330		