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
	S0011	A. BUILDING: _____ B. WING _____	C 10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE BURLINGTON	3301 STERLING DR BURLINGTON, IA 52601

(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: 32 Number of tenants with cognitive disorder: 2 Memory Care Unit (if applicable) Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 6 TOTAL Census of Assisted Living Program for People with Dementia : 40 There were no regulatory insufficiencies cited during the onsite infection control survey completed on 10/12/21. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program for People with Dementia. The following regulatory insufficiencies were cited during the investigation into Complaints #93888-C, #95233-C, #96118-C, #97248-C, #97295-C, #97607-C and # 97245-C.	A 000		
A 130	481-67.2(1)e Program Policies and Procedures 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.	A 130		

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

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the program failed to complete an incident report for an unusual occurrence involving 1 of 3 tenants (Tenant C6). Findings follow:

Interview on 9/28/21 at 2:55 PM with Staff W revealed he was working in the memory care unit helping another tenant in his apartment when he heard a ruckus. Staff W came out of the apartment and saw Tenant C6 going through the window. The area outside of the window was unsecured. Staff W called for assistance from other staff. He was unable to leave the tenants on the memory care unit to go after Tenant C6.

When interviewed on 9/28/21 at 4:27 PM Staff N (who no longer works at the program), reported she was contacted by Staff W and by the time she got to the memory care unit, Tenant C6 was gone. The Program dog, Winter, left through the window with Tenant C6. Staff T also worked and assisted in the search. Staff N recalled Staff T found Tenant C6 by the garage after she heard the dog barking. Tenant C6 was fine after the incident. Staff N thought she might have written a statement but did not create an incident report because there was no elopement. She informed the Director and Former Registered Nurse Coordinator (RNC) of the incident.

When interviewed on 9/30/21 at 4:50 PM, Staff T reported Staff W let them know a tenant got out of the building. She responded with Staff N. Staff T went around the front of the building looking for Tenant C6. There was a group of tenants from the memory care unit by the window

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A 130	Continued From page 2 Tenant C6 got out so she believed Tenant C6 had help getting through the window. When she found Tenant C6, her arms were full of belongings, which reinforced her belief the tenant was unable to get through the window alone. Staff T said it took her 5-10 minutes to locate Tenant C6. Record review failed to produce an incident report related to this incident. When interviewed on 9/22/21 at 10:20 AM, the Registered Nurse Coordinator (RNC) and Former RNC confirmed the situation with Tenant C6 was an unusual occurrence. On 9/30/21 at 1:30 PM, the Former RNC stated she felt like the system worked on their end because Staff W saw Tenant C6 exit and called for help. She confirmed there was no documentation of the event. The Former RNC said she did not realize Staff W did not follow Tenant C6 out of the building.	A 130		
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 interview and record review, the program failed to consistently follow established policies and procedures. Findings follow: 1. On 10/5/21 at 11:30 am, the surveyor entered the Program at the front door after being let in by a staff member. The staff member instructed the surveyor to take her own temperature and complete the screening log on the side table in the front entryway. The Program staff member	A 150		

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informed the surveyor the screening process was normally completed on an electric tablet, but it was not working and a paper screening process was in place. The staff member then left the area. The surveyor was not instructed to sanitize/wash her hands prior to fully entering the building.

On 10/6/21 at 8:30 am, the surveyor entered the Program at the front door after being let in by the RNC. The RNC instructed the surveyor to take her own temperature and complete the screening log on the side table in the front entryway. The RNC then instructed the surveyor to please wash her hands in the public restroom prior to entering.

On 10/7/21 at 8:30 am, the surveyor entered the Program at the front door after being let in by a staff member. The staff member then left the area and did not instruct the surveyor to complete the screening/temperature process. The surveyor was not instructed to sanitize/wash her hands prior to fully entering the building.

On 10/11/21 at 9:30 am, the surveyor entered the Program at the front door after being let in by a family member who arrived at the same time and had a key fob for family access. The surveyor took her own temperature. The family member inquired: "What do we do here?" The surveyor explained the family member needed to take her own temperature and complete the paper screening tool. A staff member came over to greet the family member. The family member stated while completing the screening tool: "I never do this process when I usually visit."

Record review revealed the Program procedure titled: "Branch Visitation Guidelines," for visitors within the electronic tablet was not available on 10/5, 10/6, 10/7, and 10/11/21. The following

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guideline was observed in the procedure document: "I will adhere to following requirements while visiting: (4.) I will sanitize my hands upon entry at the Branch and after my visit."

Staff neglected to fully instruct all visitors of the Program's expectations due to the visitation guidelines not being available.

On 10/13/21 at 10:45 am, the Director and RNC confirmed the above findings.

2. a. Record review on 10/7/21, a review of Tenant C2's closed record revealed an admission date of 10/12/20. Tenant C2 had the following diagnosis: altered mental status, Barrett's esophagus, hypertension, coronary artery disease, carpal tunnel syndrome, arthritis, dementia, depression, diverticulitis, fibromyalgia, GERD, hyperlipidemia, restless legs syndrome, and ulcerative colitis. Although no symptoms were identified on Tenant C2's weekly health screens or nurse's notes, an order for Robitussin DM was faxed to the physician for Tenant C2 on 12/31/20. On 12/31/20, Tenant C2 attended a New Year's Eve party for tenants in the dining room, per interview with the L.E.C (Activity Director) on 10/5/21 at 4:13 pm. Per nurse's notes, Tenant C2 was sent to the hospital on 1/3/21 due to complaints of difficulties breathing. Tenant C2 returned to the Program on 1/4/21 from the hospital with a diagnosis of congestive heart failure and COVID-19. Nurse's notes indicated on 1/7/21, Tenant C2 once again complained of difficulties breathing and was taken to the emergency room. Per nurse's notes, Tenant C2 expired on 1/8/21 while in the hospital.

When interviewed on 10/5/21 at 4:13 pm, the

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L.E.C stated Tenant C2 attended the New Year's Eve party but should not have. The L.E.C observed Tenant C2 having cold symptoms with frequent coughing and hacking at the party. Tenant C2 was not wearing a mask.

b. Record review on 10/7/21 revealed Tenant #4's record noted an admission date of 10/16/19. Tenant #4 had the following diagnosis: dementia, hypothyroidism, Alzheimer's disease, and hypertension. A review of Tenant #4's December medication administration record (MAR) showed Tenant #4 was administered siltussin-DM cough syrup (5 mL) by mouth twice on 12/31/20. On 12/31/20, Tenant #4 attended a New Year's Eve party for tenants in the dining room per interview with the L.E.C (Activity Director) on 10/5/21 at 4:13 pm. Tenant #4 was tested for COVID-19 on 1/4/21 and received a positive test result on 1/5/21 per lab results in her record.

When interviewed on 10/6/21 at 10:23 am, Staff H stated she observed Tenant #4 had not eaten on New Year's Eve 2020 which was unusual for her. Staff H added she observed Tenant #4 coughing a lot.

When interviewed on 10/6/21 at 1:11 pm, Staff A stated the Director and Staff J were adamant all tenants attended the party. Staff A stated Tenant #4 did not feel well and did not want to attend the New Year's Eve party on 12/23/20. Staff A observed Tenant #4 coughing and short of breath during the New Year's Eve party. Staff A stated staff were to convince all tenants who did not want to attend the party to do so anyway.

c. Tenant C2 and Tenant #4 were symptomatic on 12/31/21 but still attended the Program's New

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A 150	Continued From page 6 Year's Eve party for tenants. The Program's policy and procedure titled: "Lifting of Restricted Access - Phased-in Approach for Branch Visitation," revealed the following guidance: "The following Protocols will be in-place from Phase 4 through Phase 1:" "d.) Resident will be isolated in their apartment for signs and symptoms of infection and will be evaluated" Tenant C2 and Tenant #4 were not isolated in their apartments due to symptoms. On 10/13/21 at 10:45 am, the Director and RNC confirmed the above findings. 3. When interviewed on 10/5/21 at 4:13 pm, the L.E.C (Activity Director) stated a New Year's Eve party was held for the tenants on 12/31/20. The party had music, a ball drop, singing and party poppers. The L.E.C stated she took photos of the event as the activity department often posted photos of tenant events on the public webpage for families to view. Photos of the New Year's Eve party revealed tenants were not wearing masks (only staff were), and tenants were not social distancing at 6 feet apart. Photos showed tenants sitting in close proximity side by side in chairs and small couches. The Program's policy and procedure titled: "Lifting of Restricted Access - Phased-in Approach for Branch Visitation," revealed the following guidance: "The following Protocols will be in-place from Phase 4 through Phase 1:" "f.) 6 ft Social Distancing will be practiced by all BFMs (staff persons), Residents, and visitors" Tenants did not practice social distancing at the New Year's Eve party on 12/31/20.	A 150		

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A 150	Continued From page 7 On 10/13/21 at 10:45 am, the Director and RNC confirmed the above findings. 4. Record review on 10/12/21 revealed Tenant #10's was admitted to the Program 6/6/19. Tenant #10 had a diagnosis of dementia, anemia, coronary artery disease, hyperlipidemia, and a history of atric heart valve replacement. Nurse's notes dated 1/19/21 revealed Tenant #10 had a cough and was tired. Tenant #10 was sent to the emergency room for COVID-19 testing. Tenant #10 returned to the Program the same day with a positive COVID-19 test result. When interviewed on 10/5/21 at 3:29 pm, Staff E stated the Program held a COVID-19 vaccination clinic conducted by Walgreen's in-house. On 10/6/21, the Director gave the surveyor a list of individuals who attended the in-house vaccination clinic. Thirteen staff members and/or their family members as well as 18 tenants attended the clinic and received their first vaccination for COVID-19. The Program's policy and procedure titled: "Lifting of Restricted Access - Phased-in Approach for Branch Visitation," revealed the following guidance: Page 2, #5) "If at any time, a resident is diagnosed with COVID-19. The Branch will follow the Quick Guide-COVID-19 in your Branch, protocol." The Program's "Quick Guide: Coronavirus COVID-19 in your Branch What you Need to Know" document revealed the following guidance: "No visitors allowed." as well as, "All internal Program sponsored special events and large family gatherings are suspended."	A 150		

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A 150	Continued From page 8 The Program failed to suspend or reschedule the COVID-19 vaccination clinic in-house after one tenant tested positive three days prior to the clinic. On 10/13/21 at 10:45 am, the Director and RNC confirmed the above findings. 5. When interviewed on 9/20/21 at 1:20 PM, Staff H reported she saw Staff I grab Tenant C1 by the arm and squeeze it. Tenant C1 no longer lived at the program. Staff H reported this to one of the nurses and stated she was told Staff I did not work well with individuals who have dementia. When interviewed on 9/28/21 at 2:10 PM the Former Registered Nurse Coordinator (RNC) thought maybe she was told of this allegation but said nothing came of it. 6. When interviewed on 9/20/21 at 11:40 AM, Staff J reported she saw Staff K, who is no longer employed by the program, make fun of Tenant #17. Tenant #17 had a bowel movement and there was feces all over her body. Staff K said things to Tenant #17 such as, "What did you eat?" and "It's all over here." and "You stink!" Staff J and Staff M tried to redirect Staff K. Tenant #17 kept asking Staff K to quit making the comments to her. When interviewed on 10/5/21 at 4:05 PM Staff M recalled Tenant #17 had a bowel movement in her pants. Staff K got Tenant #17 into the shower. A co-worker and Staff M gathered Tenant #17's clothing and heard Staff K say things such as, "It smells." She couldn't recall what else Staff K said to Tenant #17, but she	A 150		

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knew Tenant #17 asked the staff to stop several times and she did not. Staff M thought this took place in January, 2021 and the comments were addressed quickly by management.

When interviewed on 10/5/21 at 11:20 AM Tenant #17 recalled Staff K as being viscous. She had a difficult time remembering details of the incident other than Staff K told her she smelled and it happened in the bathroom.

On 10/14/21 at 3:10 PM the Director reported she counseled Staff K on her actions with Tenant #17. The Director did a verbal investigation of reports from staff and Tenant #17. The Director also received reports of Staff K speaking inappropriately to Tenant #5 and telling Tenant #12 to get off the call light. The Director was unsure what Staff K said to Tenant #5. The Director did not have a written investigation of the reports involving Staff K.

7. When interviewed on 9/27/21 at 6:45 PM, Staff D reported she saw Tenant C2, who no longer lived at the program, bang on one of the windows of the building when she was in the outside courtyard. Staff I reportedly grabbed Tenant C2 by the wrist when she was trying to bring her inside, shook her by the shoulders and pushed her into a chair. Staff D said she reported this to the Former RNC. Staff D thought these actions would result in bruises to Tenant C2 but they did not.

When interviewed the Former RNC vaguely recalled a report of Tenant C2 being in the courtyard during an interview on 9/28/21 at 2:10 PM. She thought she was told it was raining that day but was sure she was not told of Tenant C2

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A 150	Continued From page 10 being jerked, shoved or pushed. The former RNC did not think she took any action on the report as Staff I denied the allegation. 8. When interviewed on 9/29/21 at 9:00, the Director and Former RNC reported Staff O, who no longer worked at the program, accused another former employee of abusing a tenant who no longer resides there. The Director could not recall the name of the tenant but thought she might remember the last name of the staff member. The Director said when she asked the accused staff member about the accusation, she became angry and quit. The program did not put the allegation in writing. They later decided it was not a valid allegation. Record review revealed the program's Abuse and Neglect policy which noted Directors and other health care professionals who have reasonable cause to believe a tenant is being, or has been abused, neglected or exploited shall report the information immediately to the State certification authority and Branch Support. Any staff member who has reasonable cause to believe a tenant is being, or has been, abused, neglected or exploited shall report the information immediately to the Branch Director or RN Coordinator. An internal investigation must be completed and documented on the investigation report form. The Director confirmed there was not a written internal investigation on the incidents of suspected abuse on 10/4/21 at 3:10 PM.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the	A 160		

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A 160	Continued From page 11 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 care, treatment and services to of 8 of 11 tenants (Tenant #5, Tenant #8, Tenant #9, Tenant #15, Tenant #16, Tenant #17, Tenant #18 and Tenant C4). Findings follow: 1. On 9/22/21 at 2:30 PM, Tenant #5 reported twice this week she received a sponge bath from staff rather than a full shower. She said this was done because it was her understanding there weren't enough staff to give her a full shower. Tenant #5 reported this happened several times. Tenant #5's Service Plan, dated 7/29/21, noted private duty would give Tenant #5 showers/whirlpools two to three times a week, staff were to do showers on the other days. 2. On 9/28/21 at 1:20 PM, Tenant #8 reported her apartment had not been cleaned for three weeks. Tenant #8 stated she didn't receive two showers a week like she was supposed to, but only perhaps two every ten days. Tenant #8's Service Plan, dated 6/4/21, revealed she should receive housekeeping one time a week and as needed. Her service plan noted she wanted to shower three times a week, on Monday, Wednesday and Friday. At times the tenant would decide to shower on her own, but	A 160		

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A 160	Continued From page 12 the program encouraged her to allow staff to set up and get her in and out of showers for safety. 3. On 9/30/21 at 9:20 AM, Tenant #9 reported her apartment had been cleaned that morning. It had not been cleaned since 9/15/21. Prior to this, her apartment had not been cleaned for three weeks. Tenant #9's Service Plan, dated 7/20/21, noted the program was to provide weekly housekeeping. 4. Record review revealed Tenant #16's Service Plan, dated 6/9/21, indicated Tenant #16 received oxygen via a nasal cannula. Staff were to assist her with the oxygen tubing and setting the correct flow at 2 liters when she was active and 1 liter when she was at rest. When interviewed on 10/4/21 at 3:25 PM, Staff Q reported she entered Tenant #16's apartment and found her oxygen concentrator unplugged, which meant she was not getting oxygen. Staff G reported on 10/4/21 at 4:10 PM she had entered Tenant #16's apartment and found her oxygen concentrator unplugged. 5. Record review revealed Tenant #15's Physician Telephone Order, dated 8/24/21, directed staff to turn/reposition him every 2-3 hours and as needed. When interviewed on 9/28/21 at 10:40 AM, Staff D reported she was notified when the order came in Tenant #15 was to be repositioned every 2-3 hours. She said this message was in the	A 160		

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communication book and she notified the CNAs. On days when the program was short staffed, Staff D might not be able to help the other staff reposition him until around "now" (10:40 AM - after 4:40 hours, longer than 2-3 hours). Tenant #15 was a large man. Staff D noticed skin break down on Tenant #15's hip on 9/27/21.

On 9/29/21 at 12:35 PM, Staff E reported they have been constantly short-staffed and it was hard to turn Tenant #15 by yourself. It had not been possible to turn him every two hours due to the staffing issues.

On 10/4/21 at 3:25 PM, Staff Q stated Tenant #15 had declined quickly. There were multiple times he paged for assistance and she was unable to get to him the care he needed. If the med aide was passing medication and Staff Q was helping in the dining room, she was unable to respond quickly. Also, she hadn't been able to turn him every four hours like his family wanted her to do. Staff Q was unaware of the order to turn him every 2-3 hours.

When interviewed on 9/28/21 at 11:20 AM Tenant #15's health care professional reported she only recently became concerned about his care at the program. Tenant #15 appeared to be wearing the same shirt on 9/28/21 (a Tuesday) as he had on Friday and the same linens were on his bed. Due to these concerns, she decided to increase the private bath aide from two to three times a week and this health care professional would now visit daily. The health care professional said she was concerned about a lack of care at the program.

When interviewed on 9/28/21 at 10:25 AM the RNC confirmed the need to turn/reposition Tenant #15 was not on his MAR or Service Plan. Staff

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were informed about the need to provide him with this care through the Communication Book.

6. A review of Task Sheets for Tenant #17 in 2021 revealed in June she was given three baths, she received one bath in July and three baths in September. A task sheet could not be located for the month of August. The Former RNC reported Tenant #17 spent her days on the memory care unit which created some confusion with her task sheet. She believed Tenant #17 received more baths than were reflected on these task sheets.

Tenant #17's Service Plan indicated staff needed to assist her with a shower twice a week. Tenant #17 was noted to have Alzheimer's and to be forgetful.

When interviewed on 9/29/21 at 11:20 AM, Tenant #17's daughter reported she viewed her mother's task sheet in her apartment and noted her mother had not been showered for days. When she asked staff about this, they told her her mother was being showered. The daughter was concerned because her mother had greasy looking hair and an odor.

When interviewed on 9/29/21 at 12:35 PM, Staff E reported she thought Tenant #17 may have had more showers than were on the task sheets because there were two task sheets for her. A second task sheet for these months was not located.

7. A review of task sheets for Tenant #18 revealed he received two showers in 3/21, five showers in 4/21, five showers in 5/21, five showers in 6/21, 0 showers in 7/21, one shower

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in 8/21 and three showers in September (through 9/29/21). Tenant #18 also received staff assistance with shaving. He shaved six times in 3/21, 11 times in 4/21, one time in 5/21, seven times in 6/21, four times in 7/21, five times in 8/21 and two times in September (through 9/29/21).

Tenant #18's Service Plans, dated 3/20/21 and 8/9/21, indicated staff were to help him shave in the morning, as he often missed areas. Tenant #18 needed assistance with showers twice a week. Staff were to allow him to do as much as possible. They were to re-approach him if he was irritable or negative. His plan noted he refused cares at times. Tenant #18 had an 180 day assessment/nurse review completed on 8/9/21. According to the form, the Registered Nurse indicated the change to his ADLs (Activities of Daily Living) was "N/A".

Further record review revealed Tenant #18's service plan, updated 8/27/21, indicated staff were encouraged to reapproach him if he was irritable or negative. Tenant #18 was noted to be someone who liked to be approached as if something was his own idea. He enjoyed taking suppers before he got off work and before supper.

8. Record review revealed Tenant C4's Service Plan, dated 5/4/21, noted she should be repositioned every two hours and as needed per her request. It was noted she required assistance with feeding three times a day due to her decline in condition. She was unable to pick up food or dink without assistance. Staff were to assist her at every meal and allow her to take her time eating. Tenant C4 received oxygen via a nasal cannula using a concentrator.

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Additional record review revealed Tenant C4 was diagnosed with Tongue cancer and Parkinson's. Tenant C4 received hospice services while living at the program. The hospice Interdisciplinary Group Meeting recertification summary dated 5/13/21 documented Tenant C4 continued to be a transfer with maximum assist of two.

When interviewed on 9/27/21 at 6:10 PM, Staff P reported Tenant C4 was a two-person transfer. If she worked alone, it was hard to reposition Tenant C4. She thought a lot of Tenant C4's sores were related to the lack of repositioning.

When interviewed on 9/29/21 at 12:35 PM, Staff E reported they were constantly short-staffed and it was hard to turn Tenant C4 by yourself. It was not possible to turn her every two hours due to the staffing issues. Staff E could not transfer Tenant C4 by herself until the tenant lost weight. She thought a lot of Tenant C4's skin breakdown happened because staff were unable to move her.

On 9/30/21 at 8:40 AM, Staff M reported she was only able to turn Tenant C4 every 2-3 hours on the day shift.

Staff G reported going into Tenant C4's apartment and seeing the oxygen canister not turned on.

When interviewed on 10/4/21 at 3:25 PM, Staff Q reported she was unable to turn Tenant C4 alone. She also said if she was busy, there were times she could not get in to feed Tenant C4 her dinner until 9:00 - 10:00 PM which made her feel bad and hope Tenant C4 got her lunch.

On 9/27/21 at 6:45 PM, Staff D reported the

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A 160	Continued From page 17 program was often short-staffed. She said when they were short-staffed, tasks didn't get finished, such as laundry, call lights getting answered quickly, showers might be done quickly and some tenants get sponge baths rather than full showers. When interviewed Staff M reported they had been so short-staffed when she worked she was sure showers were getting missed. At night, if there is enough help they are able to meet everyone's needs. If there are not enough staff, it might be difficult to get everyone turned and to the toilet the way they are supposed to. 10. On 10/12/21 at 10:45 AM the RNC explained staff informed her verbally or via their task sheets if tenant cares were not completed on their shifts. Some staff were better at this communication than others. If the RNC knew a task was not completed, she tried to get it done on the next shift. When interviewed on 10/12/21 at 10:20 AM the Director reported she had heard concerns from tenants about services not being completed. When she heard these reports, staff would pitch in to get the task completed.	A 160		
A 175	481-67.3(5) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67/3(5) To receive from the manager and staff of the program a reasonable response to all requests. This REQUIREMENT is not met as evidenced	A 175		

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by:
Based on interview and record review, the program failed to provide a reasonable response to tenants' requests, potentially affecting 8 of 10 tenants (Tenants #1, #2, #4, #5, #6, #7, #8, #9). Findings follow:

During a tour of the building with the Director on 9/20/21 at 9:45 AM, she reported the establishment was pet friendly. The Director stated at one time the program owned a dog named Winter, a Great Pyrenees, they were raising from a puppy who had puppy issues. Winter was living at a different home but they hoped to train him as a therapy dog. A slight smell of urine was noted in the hallway of the locked memory care unit, but no other odors were observed.

On 9/22/21 at 9:05 AM, Tenant #1 reported she had seen animal messes on the carpet three times but staff cleaned them up promptly when informed of them.

When interviewed on 9/22/21 at 10:00 AM Tenant #2 reported he was concerned Tenant #3 frequently brought her dog into the dining room at meal time and kept the dog on the floor by her table. Tenant #2 reported another dog pooped in the living room twice. A man in the dining room fed a dog at the table twice. Tenant #2 stated he shared his concerns with the Director but felt they were not addressed.

On 9/22/21 at 10:45 AM, Tenant #4 stated he saw a cat poop in the corner. One tenant's dog relieved himself in the hall. Another tenant is blind and almost rolled his wheelchair over the dog's waste. Tenant #3 brought her dog to the dining room and fed it from the bowls in the dining

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room. Tenant #3 reported he told staff in the dining room about the dog being there but he was not removed.

When interviewed on 9/22/21 at 2:30 PM Tenant #5 reported she did not think Tenant #3 remembered she was not to bring her dog to dinner. Tenant #5 said Tenant #3 would put her dog at her feet when she ate. Tenant #5 was upset when the program dog, Winter, came into her apartment uninvited, jumped on her bed and then urinated on her shower curtain. Winter learned how to open the apartment doors which had levers that opened by pushing them down.

When interviewed on 9/23/21 at 2:00 PM, Tenant #6 stated Tenant #3's dog was in the dining room at every meal, most every day. He had seen another tenant's dog urinate in the hall. Tenant #6 said the carpets were shampooed regularly and did not have an odor.

Tenant #7 reported seeing Tenant #3's dog in the dining room on a daily basis and felt it should not be allowed in there on 9/23/21 at 2:50 PM.. She said the program's cats sit outside her room. She was not fond of the pet situation.

On 9/28/21 at 1:20 PM, Tenant #8 stated it was not good to have pets go to the bathroom in the hallway. She had noticed an odor in the hallway. Tenant #8 reported when the program's dog, Winter, lived there, he used to be in the dining room all the time.

On 9/30/21 at 9:20 AM, Tenant #9 reported Winter would enter her apartment without her permission.

Tenant #10 and Tenant #11 expressed no

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concerns with the pets in the building.

When interviewed on 10/4/21 at 12:46 PM at the end of lunch, Tenant #4 informed the Monitor he told staff during lunch the dog was in the dining room but the staff member did not remove the dog. The Monitor informed the Registered Nurse Coordinator who got the dog out from under Tenant #3's chair and removed him from the dining room.

Record review revealed the Program's Pet Policy, which the Director was responsible for carrying out. According to the policy, pets should be cared for with respect to sanitary issues and safety hazards. The Resident's pet shall not be allowed at the program if the pet has been found to create unacceptable odors or exhibit behavior that is disruptive to other resident's safety, privacy, comfort and enjoyments. Bickford Family Members may assist residents with their pets, including control, supervision and hygiene, per instructions in their Service Plan.

Continued record review revealed Tenant #3's service plan noted staff's responsibilities to feed the dog, take the dog outside, and clean up all waste inside and/or outside. Tenant #3 may need reminding to put the dog on a leash when out of the apartment.

When interviewed on 10/12/21 at 10:20 AM the Director reported there were two program cats living in the building. Tenants residing at the program also owned a total of five dogs and two additional cats. The Director stated there were tenants who didn't want pets in the building but they were a pet-friendly program. Tenant #4 had complained about Tenant #3's being in the dining room. She confirmed the dog was not to be in

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A 175	Continued From page 21 the dining room; however if staff were busy caring for tenants' needs, they would meet their needs before dealing with the dog. Another tenant who had a dog would open his apartment door to let his dog out to urinate or defecate, which opened on an enclosed hallway and think it was the outdoors. The staff helped with the clean up. The Director reported Winter was not the dog who entered the tenants' apartments but rather another dog.	A 175		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as 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 at the ordered time to 5 of 5 tenants (Tenant #15, Tenant #2, Tenant #6, Tenant #13 and Tenant #12). Findings follow: 1. When interviewed on 10/6/21 Tenant #15 revealed she was concerned she did not receive her evening medication 10/2/21 at the correct time. Tenant #15 reported she normally received her evening pills at 8:00 PM but on 10/2/21, she did not get them until after 10:00 PM.	A 285		

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A 285	Continued From page 22 According to Tenant #15's signed Physician's Orders, dated 7/2/21, her evening medication were to be given at 8:00 PM. 2. When interviewed on 10/6/21 at 2:10 PM Tenant #2 stated he was supposed to get his medication by 8:00 PM as that is when he goes to bed. He reported he sometimes received them after 9:00 PM. Tenant #2's signed Physician's Orders were undated. The orders noted he was to receive his bedtime medication at 8:00 PM. Tenant #2's service plan, dated 5/4/21, noted he preferred to go to bed between 8:00 PM - 10:00 PM. Tenant #2's October Medication Administration Record (MAR) noted "resident did not wish to be woke up for his late administer at 10:34 PM." 3. When interviewed on 10/4/21 at 4:40 PM, Tenant #6 reported he did not receive his medication on 10/2/21 until about 11:30 PM. Due to the lateness of the delivery, he felt ill. Tenant #6's signed Physician's orders dated 8/19/21 noted his bedtime medication should be given at 8:00 PM. 4. On 10/4/21 at 4:10 PM, Staff G worked in the memory care unit on 10/2/21 from 2:00 PM - 10:00 PM. She reported the RNC administered suppertime medication to two tenants and then left. Staff G worked at the program for over a year and said she had not experienced the tenants having difficulties as they had that night.	A 285		

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Staff G stated bedtime medication was usually passed between 6:00 - 6:30 PM, but never past 8:00 PM. She had never seen Tenant #13 get out of bed herself. The tenant appeared jittery or in pain. Tenant #13 usually went to bed between 7:00 - 8:00 PM. Staff G also reported Tenant #12 was screaming and clearly in a lot of pain. She had to bring Tenant #12 out of her bedroom and into the living room.

Tenant #13's signed Physician's orders, dated 7/1/21, noted her bedtime medication was to be given at 7:00 PM.

Tenant #12's signed Physician's Orders, dated 7/22/21, noted her bedtime medication was to be given at 7:00 PM.

On 10/4/21 the RNC provided the following:
a. Tenant #13's bedtime medication administration time of 10:29 PM.
b. Tenant #12's bedtime medication was administered at 10:59 PM.
c.Tenants who did not live on the memory care unit but had staff administered medication received their medication between 10:09 PM and 11:47 PM (Tenant #5).
d. One tenant was documented as refusing his medication (Tenant #2)
e. Seven tenants did not receive their bedtime medications because they were sleeping.

The RNC confirmed these findings on 10/4/21 at 4:20 PM. She initially reported no one was available to administer the medication because a staff person called in sick. However in reviewing the schedule, she acknowledged no one was scheduled in the 2:00 PM - 10:00 PM shift as the CMA (certified medication assistant) on 10/2/21. The RNC reported generally staff could

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A 285	Continued From page 24 administer medication one hour before or after the time listed on the Physician's order to remain in compliance.	A 285		
A 290	481-67.5(2)g Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: g. Narcotics protocol, including destruction and reconciliation, shall be determined by the program's registered nurse. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to follow established narcotics protocol for 2 of 2 tenants (Tenant #12 and Tenant #13). Findings follow: Record review on 10/6/21 revealed a Scheduled Drug Count Sign-out Sheet for the Program. Employees were required to fill in the date, time and note if the narcotic count was correct for all tenants. The off-going and in-coming staff were to both signed the form each shift. On 10/2/21, Staff A signed the sheet as the off-going staff and the Registered Nurse Coordinator (RNC) signed the sheet as the on-coming staff at 3:20 PM and indicated the narcotic count was correct. The form was not signed again until until 10/3/21 at 6:00 AM. At that time, Staff B was identified as the off-going staff and the RNC signed as the on-coming staff. Both noted the narcotic count was correct. No one signed the narcotic count sheet when the RNC left and Staff B came in to work. Later that day, the RNC left at 4:00 PM and Staff C signed as the on-coming staff. No one	A 290		

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indicated the narcotic count was correct.

Further review revealed on 10/5/21, Staff D signed as the off-going staff and Staff E signed as the on-coming staff. No one signed the form indicating the count was correct.

On 10/6/21 at 11:15 AM, the RNC counted out narcotics for the monitor in the presence of Staff G and they were correct. On 10/5/21, she reported a pill for Tenant #12, Tramadol 50mg. 1/2 tablet, was missing from the card in which it is kept. All staff with access to the medication cart on that shift received drug testing.

In addition, the RNC stated the narcotic count on 10/3/21 was off for two tenants. She remembered Tenant #12 had an additional pill in a narcotic card, indicating she did not receive it the previous night, even though it was marked she did on the Medication Administration Record. The RNC said this same thing happened with another tenant, but she could not recall which tenant or what medication. The RNC had two staff members, Staff B and Staff F, witness her dispose of the narcotics, however she did not document the disposal anywhere.

When interviewed on 10/7/21 at 8:04 AM, Staff B reported when she came into work on 10/2/21, there was no off-going staff for her to do a narcotic count with. The morning of 10/3/21, the RNC told her the narcotic count was off, Tenant #12 and Tenant #13 each had one additional narcotic pill than they should, so these pills needed to be disposed of. Staff B witnessed the RNC dispose of one pill for each tenant. She was not sure during the interview the name of the pill they had disposed of for each tenant.

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A 290	Continued From page 26 The program had a Medication Management policy which noted all destruction of medications shall be reconciled in the Quickmar under med disposition. The policy also specified the Accountability of Medication and Controlled Substances. The policy noted Controlled substances shall be counted at the end of each shift and documented by each staff member involved in the process. The RNC confirmed these findings on 10/6/21 at 11:15 AM.	A 290		
A 400	481-67.19(3) Record Checks 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete background checks prior to hire for 1 of 8 employees (Staff T). Record review on 9/21/21 revealed Staff T was hired on 7/1/19. The program did not complete a criminal or abuse check for Staff T prior to her beginning work. The Director confirmed this finding on 9/22/21 at 8:50 AM.	A 400		

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A 155	Continued From page 27	A 155		
A 155	481-69.23(1)b Criteria for Admission / 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 with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program retained 2 of 4 tenants who required routine two-person assistance with transfers (Tenant C4 and Tenant C5). Findings follow: 1. Record review on 9/22/21 revealed Tenant C4 was diagnosed with Tongue cancer and Parkinson's. Tenant C4 received hospice services while living at the program. According to the hospice Interdisciplinary Group Meeting recertification summary dated 3/4/21 indicated Tenant C4 could ambulate 3-4 steps with the assist of one and a walker and required a max assist of two for transfers. The Interdisciplinary Group Meeting note dated 5/13/21 documented Tenant C4 continued to be a transfer with maximum assist of two. The Interdisciplinary Group Meeting note dated 8/5/21 also revealed Tenant C4 continued to be a max assist of two but was spending more time in bed as her functional decline had continued. Tenant C4's Service Plan dated 5/4/21 indicated she used a wheelchair for mobility and was a high fall risk. It made no reference to how staff were to assist her with transfers.	A 155		

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A 155	Continued From page 28 When interviewed on 9/20/21 at 10:10 AM, Staff D identified Tenant C4 as requiring two-person assist. On 9/20/21 10:45 AM, Staff R reported Tenant C4 became a two-person assist with transfers around 12/20. When interviewed on 9/22/21 at 12:30 PM, Staff S stated Tenant C4 had no mobility, contractures and was a two-person transfer. On 9/27/21 at 6:10 PM, Staff P said Tenant C4 was very stiff. It took two people to transfer her and even then, the tenant would cry out in pain. 2. Tenant C5 was diagnosed with heart failure and chronic kidney disease stage four. She received hospice services while living at the program. An Interdisciplinary Group Meeting was held on 4/15/21 and according to a recertification summary, Tenant C5 was noted to no longer be ambulatory. She was a max assist of two with a gait belt to pivot transfer to her chair. Tenant C5 had +3 edema to her bilateral lower extremities. Tenant C5's Service Plan, dated 12/7/20, documented she used a wheelchair. Her family noted when she fell, it was usually backwards. She had poor balance. Tenant C5 could use a side rail to assist with independence with mobility. She was a high fall risk. The plan did not address how staff were to assist her with transfers. When interviewed on 9/20/21 at 10:10 AM, Staff D identified Tenant C5 as requiring two-person assist. On 9/20/21 10:45 AM, Staff R reported Tenant C5 was a two-person transfer.	A 155		

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A 155	Continued From page 29 On 9/29/21 at 12:35 PM, Staff E described Tenant C5 as a two-person assist even before she was admitted to hospice in 12/20. 3. On 9/30/21 at 1:30 PM, the Former Registered Nurse Coordinator (RNC) confirmed there were no waivers for these tenants on hospice to exceed the level of care acceptable for the program. The RNC thought hospice wrote in the plan the ideal or safest level of transfer for the tenants. The Former RNC did not ever lift or assist staff in transferring the tenants to see what level of care the tenants needed.	A 155		
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 interview and record review, the program failed to list physician ordered tasks on the Medication Administration Record (MAR) for 1 of 1 tenant (Tenant #15): Record review on 9/28/21 revealed Tenant #15's order from his physician, dated 8/24/21, to be turned/repositioned every two to three hours and	A 330		

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A 330	Continued From page 30 as needed. Tenant #15 received hospice services. The order was not listed on his August, September or October MAR. The Former Registered Nurse Coordinator confirmed this finding on 9/30/21 at 1:30 PM.	A 330		
A 395	481-69.26(4)a 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 facility failed to include 5 of 12 current and discharged tenants' identified needs in their service plans (Tenants #15, #18, C3 and C5). Findings follow: 1. Record review revealed the following: a. A Progress Note for Tenant C3 signed by the program's Former Registered Nurse Coordinator (RNC) on 11/13/20. The note identified Tenant C3 declined and needed more assistance with toileting, dressing, bathing and hygiene. Tenant C3 received physical therapy two times a week for safety and strengthening. Tenant C3 was able to ambulate with a walker and an assist of one. She'd had a few falls and was noted to be a high fall risk with level one interventions. Tenant C3 had +2 edema in her feet. b. Tenant C3's Service Assessment, developed 11/13/20, indicated Tenant C3 required the use of a walker with the assist of one. Staff were not to	A 395		

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leave her side when ambulating. Tenant C3 used a wheelchair when she felt weak. Tenant C3 was noted to be a high fall risk with level one interventions. One of the fall prevention interventions for Tenant C3 was to keep hygiene/toiletry items in the bathroom.

c. The Former RNC placed a note in the Communication Log on 11/16/20 which noted, "Family says USE A GAIT BELT or put her in a wheelchair. Someone can follow with a wheelchair. She will be getting therapy. This should decrease falls. Needs to be toileted every two hoursQQ If an aide leaves at 1:30 PM, the second aide should check her before three and the aide coming on should be checking her ALSO. Use cream on her buttocks. She is weaker and has declined." The staff, including Staff C, signed they had read the message.

d. Tenant C3 had an appointment with her Primary Care Provider (PCP) on 12/3/21. According to the note, she had the appointment to discuss worsening mobility and to be evaluated for a wheelchair. Tenant C3 had known arthritis, poor mobility and had fallen twice trying to use a walker. Her legs were quite week. They'd tried the walker multiple times without success. She was not having pain unless she fell. Tenant C3 qualified for a wheelchair and the program was to help her determine the appropriate size.

e. Tenant C3 returned to her PCP on 12/18/21 for additional information on her wheelchair as well as a check to see if she had a urinary tract infection (UTI). The note indicated she was unable to get to activities or meals without a wheelchair. The wheelchair helped with ADLs, including self-grooming/access to toileting and the sink. Tenant C3 was unable to propel herself,

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the PCP was unsure if this was a physical or mental/confusion issue. Tenant C3's behavior had been different lately with more confusion, so she was going to be tested for a UTI.

f. Program Progress notes revealed Tenant C3 started on an antibiotic for a UTI on 12/18/21. The antibiotic was changed on 12/21/21

g. An incident report documented a CNA assisted Tenant C3 to the bathroom on 12/28/20. Tenant C3 lost her balance and fell forward to the floor. The CMA was called and found Tenant C3 laying face down with her upper body in the living room area and her lower body in the bathroom. She was checked, rolled over onto her back and then moved to a sitting position. Three staff helped her up with a gait belt and then helped her on to the toilet. Tenant C3 had a cut by her right eye which was cleaned and ice was applied to this. The RN was contacted as well as Tenant C3's family, who took Tenant C3 to the emergency room. The Incident Report identified this event occurred at 1:30 AM. Tenant C3 was sent to the University of Iowa Hospital and Clinics with a brain bleed.

Further record review revealed the tenant did not return to the Program following the incident and required skilled nursing level of care.

According to a transfer summary, Tenant C3 was mobile with a walker or wheelchair and an assist of one person.

Staff C added a statement to the 12/28/20 incident in which she wrote, "I was assisting (Tenant C3) to the bathroom for a night check when she lost balance and fell face first." The statement was dated 12/27/20.

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A 395	Continued From page 33 On 9/29/21, Staff C reported she got Tenant C3 up to use the bathroom. Tenant C3 had urinated during the night and her protective undergarment and nightgown were wet. Staff C got Tenant C3 up and walked with her across the living room to a grab bar attached to the wall outside of her bathroom. Staff C walked away from Tenant C3 towards the closet to get the tenant a dry nightgown and protective undergarment, a distance of about 24 inches. As she reached for the doorknob, she heard Tenant C3 hit the floor. Staff C did not use a wheelchair or gait belt to take Tenant C3 to the bathroom. On 9/29/21 at 12:35 PM, Staff E reported Tenant C3 was pretty much a 2-person assist. Tenant C3 was very unsteady around the time of her fall. Staff E would not have left her side. At times, staff were using a gait belt with Tenant C3. Staff E was using a wheelchair to take Tenant C3 into the bathroom where Tenant C3 would hold onto the grab bar and get onto the toilet. On 9/30/21 at 8:40 AM, Staff M reported she would keep her hands on Tenant C3 when she was walking and have her use her walker. Staff M would not have left Tenant C3 alone. She described Tenant C3 as very unsteady and dizzy in the morning and Staff M would often use the tenant's wheelchair. Staff M would use Tenant C3's walker to take her to meals when she was more steady on her feet. On 10/12/21 at 1:00 PM, the Director and RNC confirmed the Former RNC had directed staff to follow these directives. They were not in her Service Plan.	A 395		

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A 395	Continued From page 34 2. Record review on 9/28/21 revealed Tenant #15 had a Physician Telephone Order dated 8/24/21 directing staff to turn/reposition him every 2-3 hours and as needed. Tenant #15 received services through hospice while at the program due to a Metastatic Renal cell Carcinomal/Lung nodule (probable cancer) according to a hospice Interdisciplinary Group Meeting note dated 9/9/21. Tenant #15 had a Foley catheter inserted on 8/26/21 which was to be washed daily with soap and water. The hospice Registered Nurse visit dated 9/7/21 indicated Tenant #15 insisted on getting up for a bowel movement with a max assists of two, gait belt to pivot transfer. Staff attempted to explain to Tenant #15 he was too weak to get up but he was insistent and will try to get up on his own if they do not assist. Tenant #15 was eating pureed/thickened/soft foods at times. He continued to take sips of thickened Pepsi and water. Tenant #15's Service Plan, dated 9/20/21 noted Tenant #15 had a catheter. The plan did not note the catheter should be washed daily with soap and water. Another section of the plan titled Health Care Coordination, noted a catheter may be placed for comfort. The section of the plan titled Catheter/Ostomy Care noted Tenant #15 did not have a catheter but hospice could use one as needed. The Service Plan did not address the gait belt, transfers or pureed/thickened/soft foods. On 9/28/21 at 10:25 AM, the Registered Nurse Coordinator (RNC) updated Tenant #15's plan when the discrepancy on the catheter was brought to her attention. The RNC confirmed Tenant #15's other needs were not addressed on his plan.	A 395		

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3. Record review of task sheets for Tenant #18 revealed he received two showers in 3/21, five showers in 4/21, five showers in 5/21, five showers in 6/21, 0 showers in 7/21, 1 shower in 8/21 and three showers in September (through 9/29/21). Tenant #18 also received staff assistance with shaving. He shaved six times in 3/21, 11 times in 4/21, once in 5/21, seven times in 6/21, four times in 7/21, five times in 8/21 and twice in September (through 9/29/21).

Tenant #18's 3/20/21 and 8/9/21 Service Plans indicated staff were to help him shave in the morning as he as he often missed areas. Tenant #18 needed assistance with showers twice a week. Staff were to allow him to do as much as possible. They were to re-approach him if he was irritable or negative. His plan noted he refused cares at times. Tenant #18 had an 180 day assessment/nurse review completed on 8/9/21. According to the form, the Registered Nurse indicated the change to his ADLs (Activities of Daily Living) was "N/A."

Tenant #18's service plan, updated on 8/27/21, noted staff were encouraged to reapproach him if he was irritable or negative. Tenant #18 was noted to be someone who liked to be approached as if something was his own idea. He enjoyed taking suppers before he got off work and before supper.

Tenant #18's service plan was not updated until he went many weeks without receiving his planned number of showers. Interventions were not put in place to assist staff to meet his needs.

The RNC and Former RNC confirmed these

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A 395	Continued From page 36 findings on 9/22/21 at 10:20 AM. 4. Tenant C4 was diagnosed with Tongue cancer and Parkinson's. Tenant C4 received hospice services while living at the program. The hospice Interdisciplinary Group Meeting recertification summary dated 5/13/21 documented Tenant C4 continued to be a transfer with maximum assist of two. The hospice nurse documented she would ask the program to put Tenant C4 to bed after meals and turn her every two hours, but it was okay for her to sit in her chair some. The Interdisciplinary Group Meeting note dated 8/5/21 also revealed Tenant C4 continued to be a max assist of two but was spending more time in bed as her functional decline had continued. Her appetite had decreased and she was often full after a few bites. Her drinks were now thickened liquids thru a straw. She no longer went to activities. Tenant C4 had bilateral hand and arm contractures. She had unstageable wounds to her buttocks with deep tissue damage. There was excoriation with no true open areas. Tenant C4 was using a Foley catheter and was incontinent of the bowel. Tenant C4 had a Service Plan dated 5/4/21. Tenant C4's plan noted she was dependent with toileting. It did not note her incontinence of the bowel and care needs related to this. Tenant C4's plan noted she used a wheelchair for mobility. It did not note the assistance she required with transfers. There was no mention of Tenant C4 being put in bed after meals. A Progress Note indicated Tenant C4 passed away on 8/30/21.	A 395		

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A 395	Continued From page 37 The Former RNC confirmed she should have updated the Service Plan for Tenant C4 on 9/30/21 at 1:30 PM. 5. Tenant C5 was diagnosed with heart failure and chronic kidney disease stage four. She received hospice services while living at the program. An Interdisciplinary Group Meeting was held on 4/15/21 and according to a recertification summary, Tenant C5 was noted to no longer be ambulatory. She was a max assist of two with a gait belt to pivot transfer to her chair. Tenant C5 had +3 edema to her bilateral lower extremities. She passed away on 5/2/21. Tenant C5's 12/7/20 Service Plan identified she used a wheelchair. Tenant C5 could use a rail to assist with independence with mobility. There was no mention in her plan about how to transfer Tenant C5. The Former RNC confirmed she should have updated the Service Plan for Tenant C5 on 9/30/21 at 1:30 PM.	A 395		
A 420	481-69.27(1)a Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to	A 420		

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the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the program failed to complete Nurse Reviews as warranted by significant change in tenant condition and ensure appropriate interventions. This affected 5 of 12 current and discharged tenants (Tenant #15, Tenant #18, Tenant C3, Tenant C4 and Tenant C5), Findings follow:

1. Record review on 9/28/21 revealed Tenant #15 had a Physician Telephone Order dated 8/24/21 directing staff to turn/reposition him every 2-3 hours and as needed.

Tenant #15 received services through hospice while at the program due to a Metastatic Renal cell Carcinomal/Lung nodule (probable cancer) according to a hospice Interdisciplinary Group Meeting note dated 9/9/21. Tenant #15 had a foley catheter inserted on 8/26/21 which was to be washed daily with soap and water. The hospice Registered Nurse visit dated 9/7/21 indicated Tenant #15 insisted on getting up for a bowel movement with a max assist of 2, gait belt to pivot transfer. Staff attempted to explain to Tenant #15 he was too weak to get up but he was insistent and will try to get up on his own if they do not assist. Tenant #15 was eating pureed/thickened soft foods at times. He continued to take sips of thickened Pepsi and water.

A nurse review was not written to address these

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changes in his condition until 9/20/21.

2. A review of task sheets for Tenant #18 revealed he received 2 showers in 3/21, 5 showers in 4/21, 5 showers in 5/21, 5 showers in 6/21, 0 showers in 7/21, 1 shower in 8/21 and 3 showers in September (through 9/29/21). Tenant #18 also received staff assistance with shaving. He shaved 6 times in 3/21, 11 times in 4/21, 1 times in 5/21, 7 times in 6/21, 4 times in 7/21, 5 times in 8/21 and 2 times in September (through 9/29/21).

Tenant #18's 3/20/21 and 8/9/21 Service Plans indicated staff were to help him shave in the morning as he as he often missed areas. Tenant #18 needed assistance with showers twice a week. Staff were to allow him to do as much as possible. They were to re-approach him if he was irritable or negative. His plan noted he refused cares at times. Tenant #18 had an 180 day assessment/nurse review completed on 8/9/21. According to the form, the Registered Nurse indicated the change to his ADLs (Activities of Daily Living) was "N/A."

Tenant #18's service plan, updated on 8/27/21, directed staff were encouraged to reapproach him if he was irritable or negative. Tenant #18 was noted to be someone who liked to be approached as if something was his own idea.

A Nurse Review was not conducted to put interventions in place to ensure Tenant #18's needs were being met in the areas of showering and shaving.

3. Record review revealed Tenant C3 had a

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Progress Note signed by the program's Former Registered Nurse Coordinator (RNC) on 11/13/20. The note identified Tenant C3 declined and needed more assistance with toileting, dressing, bathing and hygiene. Tenant C3 received physical therapy two times a week for safety and strengthening. Tenant C3 was able to ambulate with a walker and an assist of one. She'd had a few falls and was noted to be a high fall risk with level one interventions. Tenant C3 had +2 edema in her feet.

Tenant C3's service plan, developed 11/13/20, noted Tenant C3 required the use of a walker with the assist of one. Staff were not to leave her side when ambulating. Tenant C3 used a wheelchair when she felt weak. Tenant C3 was noted to be a high fall risk with level one interventions. One of the fall prevention interventions for Tenant C3 was to keep hygiene/toiletry items in the bathroom.

The Former RNC placed a note in the Communication Log on 11/16/20 which noted, "Family says USE A GAIT BELT or put her in a wheelchair. Someone can follow with a wheelchair. She will be getting therapy. This should decrease falls. Needs to be toileted every two hours. If an aide leaves at 1:30 PM, the second aide should check her before three and the aide coming on should be checking her ALSO. Use cream on her buttocks. She is weaker and has declined". The staff, including Staff C, signed they had read the message.

Tenant C3 had an appointment with her Primary Care Provider (PCP) on 12/3/21. According to the note, she had the appointment to discuss worsening mobility and to be evaluated for a wheelchair. Tenant C3 had known arthritis, poor

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mobility and had fallen twice trying to use a walker. Her legs were quite week. They'd tried the walker multiple times without success. She was not having pain unless she fell. Tenant C3 qualified for a wheelchair and the program was to help her determine the appropriate size.

Tenant C3 returned to her PCP on 12/18/21 for additional information on her wheelchair as well as a check to see if she had a urinary tract infection (UTI). The note indicated she was unable to get to activities or meals without a wheelchair. The wheelchair helped with ADLs, including self-grooming/access to toileting and the sink. Tenant C3 was unable to propel herself, the PCP was unsure if this was a physical or mental/confusion issue. Tenant C3's behavior had been different lately with more confusion, so she was going to be tested for a UTI.

Program Progress notes revealed Tenant C3 started on an antibiotic for a UTI on 12/18/21. The antibiotic was changed on 12/21/21

A CNA was assisting Tenant C3 to the bathroom on 12/28/20. Tenant C3 lost her balance and fell forward to the floor. The CMA was called and found Tenant C3 laying face down with her upper body in the living room area and her lower body in the bathroom. She was checked, rolled over onto her back and then moved to a sitting position. Three staff helped her up with a gait belt and then helped her on to the toilet. Tenant C3 had a cut by her right eye which was cleaned and ice was applied to this. The RN was contacted as well as Tenant C3's family, who took Tenant C3 to the emergency room. An Incident Report identified this event occurred at 1:30 AM. Tenant C3 was sent to the University of Iowa Hospital and Clinics with a brain bleed.

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A 420	Continued From page 42 According to a transfer summary, Tenant C3 was mobile with a walker or wheelchair and an assist of 1. Staff C added a statement to the 12/28/20 incident in which she wrote, I was assisting (Tenant C3) to the bathroom for a night check when she lost balance and fell face first. The statement was dated 12/27/20. On 9/29/21, Staff C reported she got Tenant C3 up to use the bathroom. Tenant C3 had urinated during the night and her protective undergarment and nightgown were wet. Staff C got Tenant C3 up and walked with her across the living room to a grab bar attached to the wall outside of her bathroom. Staff C walked away from Tenant C3 towards the closet to get the tenant a dry nightgown and protective undergarment, a distance of about 24 inches. As she reached for the doorknob, she heard Tenant C3 hit the floor. Staff C did not use a wheelchair or gait belt to take Tenant C3 to the bathroom. On 9/29/21 at 12:35 PM, Staff E reported Tenant C3 was pretty much a 2-person assist. Tenant C3 was very unsteady around the time of her fall. Staff E would not have left her side. At times, staff were using a gait belt with Tenant C3. Staff E was using a wheelchair to take Tenant C3 into the bathroom where Tenant C3 would hold onto the grab bar and get onto the toilet. On 9/30/21 at 8:40 AM, Staff M reported she would keep her hands on Tenant C3 when she was walking and have her use her walker. Staff M would not have left Tenant C3 alone. She described Tenant C3 as very unsteady and dizzy in the morning and Staff M would often use the	A 420		

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tenant's wheelchair. Staff M would use Tenant C3's walker to take her to meals when she was more steady on her feet.

On 10/12/21 at 1:00 PM, the Director and RNC confirmed the Former RNC had directed staff to follow these directives. They were not in her Service Plan. A Nurse Review was not completed after the Former RNC received the directives from the tenant's family or following her appointment with her physician to obtain a wheelchair on 12/3/21.

4. Record review revealed Tenant C4 was diagnosed with Tongue cancer and Parkinson's. Tenant C4 received hospice services while living at the program. The hospice Interdisciplinary Group Meeting recertification summary dated 5/13/21 documented Tenant C4 continued to be a transfer with maximum assist of two. The hospice nurse documented she would ask the program to put Tenant C4 to bed after meals and turn her every two hours, but it was okay for her to sit in her chair some.

The Interdisciplinary Group Meeting note dated 8/5/21 also revealed Tenant C4 continued to be a max assist of two but was spending more time in bed as her functional decline had continued. Her appetite had decreased and she was often full after a few bites. Her drinks were now thickened liquids thru a straw. She no longer went to activities. Tenant C4 had bilateral hand and arm contractures. She had unstageable wounds to her buttocks with deep tissue damage. There was excoriation with no true open areas. Tenant C4 was using a Foley catheter and was incontinent of the bowel.

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A 420	Continued From page 44 Tenant C4 had a Service Plan dated 5/4/21. Tenant C4's plan noted she was dependent with toileting. It did not note her incontinence of the bowel and care needs related to this. Tenant C4's plan noted she used a wheelchair for mobility. It did not note the assistance she required with transfers. There was no mention of Tenant C4 being put in bed after meals. A Progress Note indicated Tenant C4 passed away on 8/30/21. A Nurse Review was not written to address Tenant C4's change in health and interventions to address her needs. 5. Record review revealed Tenant C5 was diagnosed with heart failure and chronic kidney disease stage four. She received hospice services while living at the program. An Interdisciplinary Group Meeting was held on 4/15/21 and according to a recertification summary, Tenant C5 was noted to no longer be ambulatory. She was a max assist of two with a gait belt to pivot transfer to her chair. Tenant C5 had +3 edema to her bilateral lower extremities. She passed away on 5/2/21. Tenant C5's 12/7/20 Service Plan identified she used a wheelchair. Tenant C5 could use a rail to assist with independence with mobility. There was no mention in her plan about how to transfer Tenant C5. A Nurse Review was not conducted to identify interventions to address her change in condition. 6. The Director and RNC confirmed these	A 420		

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A 420	Continued From page 45 findings on 10/12/21 at 1:00 PM.	A 420		
A 465	481-69.28(5) 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 provide an orientation and annual in-service on food safety and sanitation to 6 of 8 employees (Staff T, Staff M, Staff I, Staff U, Staff R and Staff B). Findings follow: 1. Record review revealed Staff T was hired on 7/1/19. She received an orientation on Food Safety and Sanitation on 7/11/19 but no annual in-service after that date. 2. Record review revealed Staff M was hired on 1/30/17. She received an orientation on Food Safety and Sanitation on 1/30/17. She received annual in-services on 8/1/18 and 6/1/21 but nothing in 2019 or 2020. 3. Record review revealed Staff I was hired on 4/18/18. She received an orientation on Food Safety and Sanitation on 4/25/18. Staff I received annual in-services on 8/17/18 and 6/1/21 but nothing in 2019 or 2020. 4. Record review revealed Staff U was hired on 7/15/19 and received an orientation on Food	A 465		

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A 465	Continued From page 46 Safety and Sanitation on 8/5/19. Staff U did not receive any in-services after that date. 5. Record review revealed Staff R was hired on 8/27/20. She did not receive an initial orientation on Food Safety and Sanitation. She did receive an in-service on 6/1/21. 6. Staff B was hired on 3/21/20. She did not receive an initial orientation on Food Safety and Sanitation. She did receive an in-service on 6/1/21. 7. The Director confirmed these staff members served food and did not received the required training's on 9/22/21 at 8:50 AM.	A 465		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of 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 provide eight hours of dementia-specific education and training within 30- days of employment for 5 of 8 employees (Staff U, Staff R, Staff B, Staff D and Staff V). Findings follow: 1. Record review on 9/21/21 revealed Staff U was hired on 7/15/19. She received 1 hour of	A 545		

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A 545	Continued From page 47 dementia training within 30 days, but not the required full eight hours of dementia-specific training within 30-days of beginning employment. 2. Record review revealed Staff R was hired on 8/27/20. She received 2 hours of dementia training on 9/1/20, but not the required full eight hours of dementia-specific training within 30-days of beginning employment. 3. Record review revealed Staff B was hired on 3/21/20. She did not receive any dementia-specific training within 30-days of employment. 4. Record review revealed Staff D was hired on 7/14/20. She received 2 hours of dementia-specific training on 7/21/20, but not the required full eight hours of training. 5. Record review revealed Staff V was hired on 3/26/20. She did not receive any dementia-specific training within 30-days of employment. 6. The Director confirmed these findings on 9/22/21 at 8:50 AM.	A 545		