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 09/17/2024

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. Number of tenants without cognitive impairment: 23 Number of tenants with cognitive impairment: 11 Total census: 34 No regulatory insufficiencies were cited during the investigation into Incident #120563-I. The following regulatory insufficiencies were cited during the investigation into Complaint #120852-C.	A 000	The Plan of Correction is attached.	
A 135	481-69.22(1) Evaluation of Tenant 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. This REQUIREMENT is not met as evidenced by:	A 135		

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A 135	Continued From page 1	A 135		

Based on interview and record review, the program failed to complete thorough evaluations prior to admission to ensure services were available to meet the needs of 1 of 1 former tenants reviewed (Tenant C1). Findings follow:

Review of Tenant C1's file on 9/12/24 revealed a move-in date of 5/1/24.

The file included an inpatient psychiatry note from the Veterans Administration (VA) dated 4/22/24 documenting Tenant C1 was a 77 year old male. He had several days in which he had 4-5 hours of sleep overnight and increased sleep during the day. He continued to be unsteady on his feet, sometimes falling asleep standing up. During an exam, Tenant C1 was noted to be intermittently awake to falling asleep on his feet.

An inpatient progress note from the VA dated 4/28/24 documented Tenant C1 continued to be agitated and mildly aggressive. He was redirectable. Tenant C1 continued to wander around the unit fidgeting with things. He moved furniture, took his clothing off and invaded his peers' space.

A registered nurse (RN) completed a move-in Resident Assessment for Tenant C1 on 4/25/24. The RN noted Tenant C1 received psychiatric services from the VA. He had moderate cognitive needs due to disorientation, memory loss and difficulty completing tasks. Tenant C1 was continent and independent with toileting. He had a history of pacing and wandering. He was easily redirected by taking his hand and walking with him. The nurse indicated Tenant C1 required no support or assistance due to behavioral disturbances. Tenant C1 needed minimal support in managing his occasional inconsistent sleep

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A 135	Continued From page 2	A 135		

patterns. The RN wrote in a 4/25/24 progress note, per the VA, Tenant C1 had no behaviors towards staff or other patients.

Program progress notes revealed the following information:

- On 4/25/24, the program's Health and Wellness Director (HWD) contacted a nurse at a program in which Tenant C1 previously resided requesting any notes they had on his admission. The nurse stated she did not have many notes, but while Tenant C1 resided there, he was exit-seeking at night and aggressive with staff.
- Tenant C1 arrived at the program on 5/1/24 at 11:30 AM. He appeared very drowsy. Staff at the VA advised Tenant C1 preferred hands off help in the restroom as he was a very private man.
- On 5/2/24 at 4:57 AM, Staff A documented Tenant C1 did not sleep at all that night. He did take a few power naps which lasted 1-8 minutes and would get back to pacing around. Tenant C1 flipped over recliners, tried yanking the wooden ironing board off the wall and picked up the television. He pulled on the cabinets in the kitchen. He continued doing these things until the morning. Medication was administered around 11:00 PM to help Tenant C1 calm down. When Staff A attempted to provide toileting assistance, Tenant C1 grabbed her arms and asked for oral sex. Tenant C1 would not allow staff to get his pants pulled all the way up for a long period of time.
- On 5/3/24 at 4:20 AM, Tenant C1 was not sitting throughout the night and fell down when sleeping standing up. Tenant C1 urinated on the floor in the living room. When staff tried to get him to use the restroom, he started to punch, squeeze the hands of staff and ram them with his walker when they tried to get his incontinence undergarment on.

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A 135	Continued From page 3 - Throughout the morning of 5/3/24, Tenant C1 slapped and grabbed at staff when they attempted to help him with toileting, beginning at 9:48 AM. His son and daughter were with him at 11:17 AM when the HWD went to administer some medication to help calm him down. Tenant C1 was falling asleep standing up. A chair was brought for him to sit in and it took much prompting for him to use it. Tenant C1's behaviors were discussed with his family. - Staff B attempted to administer medication to Tenant C1 at 11:17 AM. When doing so, Tenant C1 grabbed her hand and tried to bite her. Tenant C1 fell asleep 4 separate times while standing up. Staff B attempted to redirect him by offering him fidget toys, snacks, a chair and encouraging him to go to his room to rest. Three employees tried to assist Tenant C1 with changing his soiled incontinence brief at 11:52 AM. He slapped, grabbed and squeezed the employees' hands and arms. At 12:09 PM, the HWD contacted the VA clinic for information about caring for Tenant C1. - On 5/3/24 at 1:19 PM it was documented the HWD spoke with Tenant C1's wife about his behaviors such as sleeping when standing up, grabbing staff, inappropriate sexual behaviors (such as grabbing staff's hands and attempting to make them touch his genitals and exposing himself in common areas) and reported the wife would need to sit with Tenant C1 or have him evaluated at the VA if the behaviors continued. - On 5/3/24 at 10:07 PM, Staff C found Tenant C1 in the salon urinating on the floor. When Staff C tried to redirect Tenant C1, he punched Staff C in the stomach. Staff C attempted to guide Tenant C1 out of the salon while the floor was covered in urine. Tenant C1 threw himself to the ground. Staff C requested assistance getting the tenant off the floor. He threatened to hurt Staff C the	A 135		

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next time this happened. Tenant C1 continued to display anger by pulling on the cabinets and spitting. The staff called 911. Tenant C1 was transported back to the Veteran's Hospital.
- Tenant C1's family was issued an emergency, involuntary discharge notice on 5/3/24.

On 9/12/24 at 2:15 PM, Staff A reported she knew the VA told the program Tenant C1 was continent but he was not continent at their program. Tenant C1 urinated by the fish tank and trash can. They told their bosses what Tenant C1 was doing and they were told to redirect him but this did not work

During interviews on 9/11/24 and 9/12/24, Staff B reported she interacted with Tenant C1 on his first day at the program when he grabbed her hand, put it on his penis following the toileting process and she told him to stop. Tenant C1 then pulled up his own pants. After this, Tenant C1 did not toilet on his own. He did not follow directions from staff.

The program had information from the VA about the way Tenant C1 fell asleep standing up, took off his clothing and invaded the space of others. He was noted to be agitated and mildly aggressive. These behaviors were not fully explored in the health, functional and cognitive evaluations which might have assisted in deciding if Tenant C1 was an appropriate candidate to live at the program.

On 9/12/24 at 1:00 PM the former Executive Director reported staff were trained to deal with individuals who had behaviors, however they decided to discharge Tenant C1 because the way he presented at the program was inconsistent with the information provided prior to his admission, including the move-in Resident

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A 135	Continued From page 5 Assessment.	A 135		
A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure the preliminary service plan was developed and signed by all parties prior to taking occupancy for 1 of 2 former tenants reviewed (Tenant C1). Findings follow: On 9/12/24 review of a service plan for Tenant C1 identified he moved to the program on 5/1/24. The service plan was signed by the program's Registered Nurse on 5/2/24 and Tenant C1's representative on 5/3/24. Tenant C1's representative signed the Admission Agreement (occupancy agreement) on 5/1/24, the date Tenant C1 moved to the program. The Executive Director confirmed this finding on 9/12/24 at 9:44 AM.	A 355		

A 135 481-69.22(1) Evaluation of Tenant

Regulatory Insufficiency: The program failed to complete thorough evaluations prior to admission to ensure services were available to meet the resident's needs.

Plan of Correction:

The insufficiency will be corrected as follows:

- Tenant C1 no longer resides at Burlington Bickford Cottage

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

- The Divisional Director of Operations or designee will review Chapter 69, 481—69.23(231C) Criteria for admission and retention of tenants and PP-60300 – Application Approval Criteria with the Health & Wellness Director, Executive Director and Family Advocate by 10/15/2024

The program will monitor performance to ensure compliance as follows:

- The Divisional Director or designee audit all new resident service plans periodically for the next 6 months (ending 4/11/2025)

Date deficiencies corrected by: 10/31/2024

A 355 481-69.26(2) Service Plans

Regulatory Insufficiency: The program failed to ensure the preliminary service plan was developed and signed by all parties prior to taking occupancy.

Plan of Correction:

The insufficiency will be corrected as follows:

- Tenant C1 no longer resides in the community.

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

- The Divisional Director of Operations or designee will review Service Planning and Agreements with the Health & Wellness Director, Executive Director and Family Advocate by 10/15/2024

The program will monitor performance to ensure compliance as follows:

- The Divisional Director or designee will randomly audit new resident service plans and admission agreement signature dates for the next 6 months.

Date deficiencies corrected by: 10/31/2024