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
	S0054	A. BUILDING: _____ B. WING _____	C 01/19/2022

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

(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: 25 Number of tenants with cognitive disorder: 9 Memory Care Unit Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 3 TOTAL Census of Assisted Living Program for People with Dementia : 38 No regulatory insufficiencies were cited during the onsite infection control visit. The following regulatory insufficiencies were cited during the investigation of Complaint #101520-C, Complaint #97727-C and the recertification visit conducted to determine compliance with certification for an Assisted Living Program for People with Dementia.	A 000		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provided the required 2 hours of dependent adult abuse training within six months	A 380		

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A 380	Continued From page 1 of hire as required. This pertained to 2 of 8 staff reviewed (Staff B and Staff C). Findings follow: Record review on 1/18/22 revealed the following: 1. Staff B had a start date of 9/28/20. No Dependent Adult Abuse training completed within six months of employment could be located. 2. Staff C had a start date of 1/18/21. No Dependent Adult Abuse training completed within six months of employment could be located. The Community Relations Director confirmed these findings on 1/18/22 at 3:25 PM.	A 380		
A 320	481-69.25(1)o Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record) This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to maintain incident reports as required for 2 of 3 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Record review of Tenant C1's Progress Notes on 1/19/22 revealed the following entries:	A 320		

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A 320	Continued From page 2 a. 6-2-20 Tenant #C1 exited the west door at 3:30 a.m. and set off the alarm. Staff brought him back inside. b. 6-5-20 staff called for assistance when Tenant #C1 exited out the 300 hall and resisted staff redirection to return. He wanted to get his truck and go home. Tenant C1 became agitated and followed staff into other tenants' apartments. Another tenant paged staff at 6:30 AM and reported Tenant C1 entered his apartment and fell on the floor as he was leaving. Tenant #C1 yelled at staff when they arrived to help him off of the floor. No Unusual Occurrence Reports for these incidents could be located. 2. Record review of Tenant C2's Progress Notes on 1/19/22 revealed falls on 1/15/20, 1/16/20 and 2/22/20. No Unusual Occurrence Reports for these incidents could be located. The Community Relations Director and RN Coordinator confirmed these findings on 1/19/22 at 4:30 PM.	A 320		
A 390	481-69.26(3)e Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. e. The service plan shall be reviewed, updated if necessary, and signed and dated by all parties at	A 390		

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A 390	Continued From page 3 least annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to have all parties sign the Service Plan for 3 of 3 discharged tenants reviewed (Tenant C2 and Tenant C3). Findings follow: 1) Tenant's C1's 1/23/19 Service Plan was signed by the Director and RN. Tenant C1's 2/26/19 Service Plan was signed by the Director, RN and Tenant. Tenant C1's 3/29/19 Service Plan was signed by the Director, RN and Tenant. Tenant C1's 9/25/19 Service Plan was signed by the Director, RN and Tenant. Tenant C1's 4/2/20 Service Plan was not signed by the RN or Tenant. The appropriate parties did not sign the 1/23/19 Service Plan or the 4/2/20 Service Plan. 2) Tenant C2 signed a document designating her daughter as her attorney in fact on 9/25/14. Tenant C2 had a Service Plan dated 1/31/19 signed by Tenant C2, the Director and the RN. Tenant C2 had a Service Plan dated 8/6/19 signed by Tenant C2, the Director and the RN. On 9/6/19, the attorney in fact signed the Service Plan. The RN noted on the Service Plan on 9/6/19, all forms, paperwork and service plans must be signed by the POA, not Tenant C2. A Service Plan dated 1/26/20 was signed by the attorney in fact, the Director and the RN. The appropriate party did not sign the 1/31/19 Service Plan and did not initially sign the 8/6/19 Service Plan.	A 390		

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A 390	Continued From page 4 3) Tenant C3 signed a document on 7/13/04 designating her daughter as her attorney in fact. Tenant C3 had a 3/20/19 Service Plan signed by Tenant C3, the Director and the RN. Tenant C3 had a 9/19/19 Service Plan signed by the attorney in fact, the Director and the RN. The appropriate party did not sign the 3/20/19 Service Plan. The Community Relations Director and RN Coordinator confirmed these findings on 1/19/22 at 4:30 PM.	A 390		
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 program failed to update service plans to reflect the identified needs and preferences for 3 of 3 discharged tenants reviewed (Tenant C1, Tenant C2 and Tenant C3). Findings follow: 1. Record review of Tenant C1's file on 1/19/22 revealed the following: Progress Notes revealed the following: a. On 1/23/20 Tenant C1 experienced numerous	A 395		

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falls with confusion within the last week. He experienced minor injuries of bruises to his bilateral arms, back, sides, abrasions to his right elbow and forehead. Tenant C1 completed therapy within the last ten days and experienced multiple falls after discharge. The RN instructed caregivers to utilize the wheelchair to transport tenant C1 to and from meals and activities to ensure his safety. Tenant C1 exhibited increased confusion with some agitation towards caregivers and his wife. Tenant C1 exhibited new behaviors and included he searched for his care, looked out exit doors and looked to return to his home. The RN noted she would review the Service Plan and updated it with any changes necessary.

b. On 1/30/20 a physical therapist met with Tenant C1 to resume services. The therapist reported Tenant C1 presented stronger than following discharge from therapy on 1/15/20. The physical therapist believed Tenant C1's falls were related to the progression of his dementia rather than physical disability or pain.

c. On 1/30/20 Tenant C1 yelled at staff because he did not know where his wife was. Staff escorted him to his room and let him be.

d. On 2/3/20 Tenant C1 fell on 2/1/20 without injury and continued to complain of pain in his bilateral extremities. The RN encouraged staff to transport him to the dining room when he was feeling weak or unsteady. Tenant C1 exhibited an increase in agitation, refusal of cares, refusal of meals, increased lethargy and angry outbursts, decreased awareness of safety risks.

e. On 2/20/20 staff found him on the floor in his apartment after he attempted to transfer himself from the wheelchair to his walker. The RN

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scheduled an appointment with his primary care provider (PCP) for the following day and noted a noticeable increase of memory deficits.

f. On 2/21/20 Tenant C1's physician diagnosed he strained his groin and had rash related to incontinence along his groin. It noted continued therapy and utilization of the wheelchair for long distances to allow the groin strain to heal. The physical therapist reported concerns of the dementia progression and decreased awareness of safety to his wife.

g. On 3/25/20 a Nurse Review documented he ambulated with his walker with apparent difficulty. Tenant C1 exhibited unawareness of safety hazards and made poor decisions regarding his safety, especially noted with ambulation. Tenant C1 exhibited forgetfulness to ask for assistance due to the progression of his dementia. The RN noted caregivers provided him with wheelchair transport. Staff noticed an increase in incontinence and noted he threw soiled clothing in the trash. Caregivers attempted to anticipate his needs but Tenant C1 became upset or agitated at time. These behaviors increased when his wife had not visited for days. The nurse noted she would complete assessment, review the service plan, and make changes as needed.

The Service Plan dated 9/25/19 indicated Tenant C1 required encouragement to attend meals in the dining room and document refusals. He often requested a room tray for breakfast. He wore incontinence undergarments and required encouragement to use the bathroom before and after meals, at bedtime and as needed due to incontinence. He required help maintaining proper hygiene at times and to ensure he wore clean undergarments. Tenant C1 utilized a rolling

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walker and required no staff assistance with ambulation following therapy services. He required physical and occupational therapy for strengthening and endurance training for a history of falls. Tenant C1 exhibited short term memory loss but easily redirected, noted to be alert and oriented to person, place and time with confusion regarding the current situation.

The Program failed to update the service plan dated 9/25/19 to address his repeated falls, need for staff to transport him with a wheelchair, increased incontinence, decreased cognition, refusal of cares, and safety concerns.

2. Record review of Tenant C1's file on 1/19/22 revealed the following:

Progress Notes revealed the following:

a. On 4/16/20 The 200 hallway exit door alarmed when he exited to the outside at 3:00 AM to look for his car to go home and staff assisted him inside.

b. On 4/23/20 the Program notified his physician on the continued increase in confusion, attempts to leave the building, visual hallucinations, and requested a urinalysis test and a referral for palliative care or hospice.

c. On 4/28/20 his Power of Attorney (POA) approved hospice care and the urinalysis came back normal.

d. On 5/18/20, 5/19/20 and 5/22/20 he experienced falls.

e. On 6/2/20 at 3:30 AM he exited the west exit door to the outside and set off the alarms. A staff

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turned Tenant C1 around and brought him inside.

f. On 6/2/20 he experienced increased restlessness, exit-seeking behaviors, and pain despite the recent addition of pain medication.

g. On 6-5-20 staff called for assistance when Tenant #C1 exited out the 300 hall and resisted staff redirection to return. He wanted to get his truck and go home. Tenant C1 became agitated and followed staff into other tenants' apartments. Another tenant paged staff at 6:30 AM and reported Tenant C1 entered his apartment and fell on the floor as he was leaving. Tenant #C1 yelled at staff when they arrived to help him off of the floor.

h. On 6/12/20 he fell and scraped his knee and had a black eye. He moved to the memory care unit for increased supervision.

i. On 6/13/20 he displayed a high level of agitation and refused his anxiety medication .

j. On 6/14/20 he refused incontinence care assistance from staff twice.

k. On 6/17/20 staff found him on the floor in his apartment.

l. On 6/19/20 he fell in the night and scraped on his forehead.

m. On 6/20/20 he refused cares on 3rd shift .

n. On 6/30/20 at 6:20 AM staff discovered undressed from the waist down and he had been incontinent. He displayed verbal and physical aggression when staff attempted to provide incontinence cares. He yelled and thrashed in

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bed throughout the morning and refused medication for pain or anxiety.

o. On 7/5/20 he slid out of his wheelchair in the dining room. He yelled and hit at two staff as they tried to get him into his wheelchair and to his bed.

p. On 7/7/20 he hit a staff member in the face and threatened another staff as they provided cares .

The Service Plan dated 4/2/20 revealed he required a wheelchair for longer distances due to decreased strength of lower extremities. The Program failed to update the service plan to reflect the addition of hospice service, the move to the memory care unit, increased in falls, increased refusals of cares, and increased verbal and physical aggression, and exit-seeking behaviors.

3. Record review of Tenant C2's Progress Notes on 1/19/22 revealed the following:

a. On 8/9/19 she experienced episodes of nausea and vomiting in the morning and at lunch. She received Zofran (a medication used to prevent vomiting and nausea) and peppermint and were not successful.

b. On 9/1/19 she experiences nausea and sickness during the whole shift. She received two peppermints and a nausea pill.

c. A 90-day Assessment dated 11/4/19 noted episodes of nausea occurred periodically and requested peppermint candy. She requested anti-nausea medication if the peppermint was ineffective and received zofran more than thirty times this assessment period. She continued to receive a prophylactic antibiotic daily for UTI

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prevention.

d. On 11/11/19 she received a peppermint due to an upset stomach and vomited at the dining room table.

e. On 11/14/19 a urine sample was collected for a urinalysis. She experienced notable weight loss over the last month and increased confusion, lethargy, nausea and intermittent vomiting. She increased her use of zofran and her appetite and meal consumption declined.

f. On 11/21/19 the RN received an order from hospice for a pleasure food diet and to update the service plan.

g. On 1/14/20 she received zofran for vomiting and was not effective. Staff contacted Hospice was contacted and they prescribed two new medications for nausea.

The Program failed to update the service plan dated 8/6/19 to reflect intermittent nausea and treatment and recurrent urinary tract infections.

4. Record review of Tenant C2's Progress Notes on 1/19/22 revealed the following:

a. On 2/24/20 a Nurse Review Fall and Change in Condition identified she experiences a transition toward the end of life. Hospice placed her on comfort measures and included to remain in bed, reposition frequently, offer fluids as tolerated, and medications as needed.

The Service Plan dated 8/6/19 indicated she required incontinence undergarments for occasional incontinence, toileting assistance upon rising in the morning, before or after each

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meal, before retiring for the evening, and as needed. No mention was made of her history of urinary tract infections. Staff were to provide verbal reminders of all meal times to Tenant C 1. She was identified as being independent with eating. She was on hospice and some weight loss could be expected.

The Program failed to update the service plan dated 1/26/20 to reflect comfort measure for end of life care.

5. Record review of Tenant C3's Progress Notes on 1/19/22 revealed the following:

a. On 10/15/19 she appeared very confused and agitated at supper and threw her plate. She yelled and pushed staff away as they tried to move her from the table.

b. On 10/17/19 she refused a showered and seemed paranoid and noticeably emotional.

c. On 10/21/19 the RN updated her physician for her increased confusion and episodes of extreme agitation and delusional thoughts.

d. Tenant C3 was admitted to hospice on 11/25/19.

The Program failed to update the service plan dated 9/19/19 to reflect interventions for behavior and agitation, and hospice admission.

The Community Relations Director and RN Coordinator confirmed these findings on 1/19/22 at 4:30 PM.

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A 545	Continued From page 12	A 545		
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 within 30 days of employment. This pertained to 8 of 8 employees reviewed (Staff A, Staff B, Staff C, Staff D, Staff E, Staff F, Staff G and Staff H). Findings follow: Record review of staff files on 1/18/22 revealed the following: Staff A was hired on 12/14/21. No dementia-specific training within 30 days of employment could be located. Staff B was hired on 9/28/20. No dementia-specific training within 30 days of employment could be located. Staff C was hired on 1/18/21. She completed 2.5 hours of dementia-specific training. No further dementia-specific training within 30 days of employment could be located. Staff D was hired on 1/28/21. No dementia-specific training within 30 days of employment could be located.	A 545		

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A 545	Continued From page 13 Staff E was hired on 11/24/21. No dementia-specific training within 30 days of employment could be located. Staff F was hired on 12/13/21. No dementia-specific training within 30 days of employment could be located. Staff G was hired on 12/6/21. No dementia-specific training within 30 days of employment could be located. Staff H was hired on 12/7/21. No dementia-specific training within 30 days of employment could be located. On 1/18/22 at 3:25 PM the Community Relations Director confirmed these findings. She reported staff members hired in November and December of 2021 were unable to complete their dementia-specific training within 30-days due to an outage with the program's computer system in December which was unresolved at the time of the recertification visit.	A 545		

Plan of Correction
Davenport Bickford Cottage

A 380—481.67.9(6) Staffing

Regulatory Insufficiency: The program failed to provide the required 2 hours of dependent adult abuse training within six months of hire as required.

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

- Staff B and Staff C will complete 2 hours of dependent adult abuse training as required by 3/9/22.

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

- Divisional Director of Operations provided re-education to director state requirements for dependent adult abuse training of all staff on 1/24/22.
- Director will audit all current staff files for compliance with completion of 2 hours of dependent adult abuse training. Those not in compliance will complete the training by 3/9/22.
- Director will assign and audit new hires monthly for compliance/completion with state required dependent adult abuse training.

The program will monitor performance to ensure compliance as follows:

- The Director will complete a monthly audit for compliance/completion of state required dependent adult abuse training within 6 months of hire.
- Divisional Director of Operations or designee will audit staff files twice per year to ensure compliance.

Date deficiencies corrected by: 03/9/2022

A 320-481-69.25(1) – Tenant Documents

Regulatory Insufficiency: Program failed to maintain incident reports as required for discharged residents.

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

- Tenant C1 and Tenant C2 no longer reside in the community.

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

- Divisional Director of Resident Services provided education on 2/21/22 to new RNC regarding retention of tenant document following discharge.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Resident Services or designee will audit discharged tenant files twice per year to ensure incident reports are properly maintained.

Date deficiencies corrected by: 02/23/2022

A 390-481-69.26(3)e – Service Plans

Regulatory Insufficiency: Program failed to have all parties sign the Service Plan.

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

- Tenant C2 and Tenant C3 no longer reside in the community.

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

- Divisional Director of Resident Services provided education to the new RNC on the Service Planning and Agreements policy on 2/21/22.

The program will monitor performance to ensure compliance as follows:

- Director or designee will audit all tenant service plans monthly to ensure all persons who developed the plan have reviewed and signed for 90days and then prn.
- Divisional Director of Resident Services or designee will audit Service Plans twice per year to ensure all required signatures have been obtained.

Date deficiencies corrected by: 02/23/2022

A 395-481-69.26(4)a – Service Plans

Regulatory Insufficiency: Program failed to update service plans to reflect the identified needs and preferences.

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

- Tenant C1, Tenant C2 and Tenant C3 no longer reside in the community.

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

- Divisional Director of Resident Services provided education to the new RNC on the Service Planning and Agreements policy on 2/21/22.
- RNC will complete Assisted Living RN training course provide through IHCA by August 30, 2022

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Resident Services or designee will audit resident documentation including service plans twice per year to ensure resident needs and preferences are noted on service plan.

Date deficiencies corrected by: 02/23/2022

A545-481-69.30(1) – Dementia Specific Education for Personnel

Regulatory Insufficiency: Program failed to provide eight hours of dementia-specific education within 30 days of employment.

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

- Staff A, Staff B, Staff C, Staff D, Staff E, Staff G and Staff H will complete 8 hours of dementia-specific education by 3/9/22.

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

- Divisional Director of Operations provided education to the Director on the Dementia Training Policy on 1/24/22.
- Director will audit all current Staff files for non-compliance of dementia -specific training that did not occur within 30 days of hire.
- Director will assign any staff who is out of compliance with dementia-specific training to be completed by 3/9/22
- Director will run bi-weekly reports in program's CMR to ensure dementia-specific training has been completed as assigned.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Operations or designee will audit program's CRM monthly to ensure 8 hours of dementia-specific training has occurred for all staff within 30 days of hire.

Date deficiencies corrected by: 03/9/2022