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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 03/30/2023

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

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A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 21 Number of tenants with cognitive disorder: 14 TOTAL census of Assisted Living Program for People with Dementia: 35 The following regulatory insufficiencies were cited during the investigation of Complaints #111838-C and #111846-C. No regulatory insufficiencies were cited during the investigation of Complaint #111633-C.	A 000	See Attached POC 6/14/23	
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the 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 adequate and appropriate care, treatment and services for 1 of 1 tenants observed with exit seeking behaviors (Tenant #1). Findings follow: Observations on 3/23/23 at 11:51 a.m. revealed Tenant #1 walked back and forth in the memory	A 160		

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

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A 160	Continued From page 1	A 160		

care unit and went to the exit door three times within 20 minutes. Staff followed and redirected him away from the door each time but he returned after a few minutes. He continued to walk around the unit and attempted to open the other tenant apartment doors. The doors remained locked due to his history of opening them and going through their belongings. Tenant #1 looked through books and moved them around then paced around the unit. Staff brought him a lunch tray and encouraged him to sit down to eat but he continued to walk around for a short time then sat down in a recliner and ate his lunch.

Record review on 3/23/23 of Tenant #1's file revealed the following:

Progress Notes for the month of January 2023 revealed he moved in on 1/9/23. Documention revealed four incidents of aggression and required a call to 911 once, two attempts to exit the building, and he entered other tenant's apartments uninvited at least four times.

Progress Notes for the month of February noted nine incidents of aggression required a call to 911 on three occasions, three attempts to exit the building, and he continued to enter other apartments uninvited. Continued review revealed on 2/11/23 staff attempted to redirect Tenant #1 from the exit door and he repeatedly punched her in the face. Staff called 911 and he was transported to the emergency room and returned 2/13/23 with orders to administer Ativan as needed for behavior. Progress notes dated 2/24/23 documented he verbally threatened to knock out a staff and was unable to calm down. Staff called 911 and he was transported to the hospital. On 2/25/23 staff were unable to redirect him as he paced throughout the building and he

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displayed verbal and physical aggression. Staff called 911 and he was taken to the hospital.

Progress Notes for Month of March 2023 indicated on 3/1/23 he returned from the emergency room with new orders for Zyprexa to be given as needed for behavior and added a 1:1 caregiver from 10 p.m. to 8 a.m.. Notes on 3/9/23 documented he slept through the night the past three nights and 1:1 would be discontinued on 3/15/23. Continued review of notes dated 3/13/23 revealed he exhibited exit seeking behaviors over the weekend but staff easily redirected him.

Record review of the dispatch report provided by the police department revealed Emergency Medical Services (EMS) and/or the police department visited the Program once in January and three times in February for concerns related to Tenant #1.

Tenant #1's Service Plans dated 1/26/23 and 1/30/23 failed to include the behaviors of aggression, exit seeking, and wandering into other apartments uninvited and interventions to minimize them.

No updated service plans to reflect his ongoing aggression, exit seeking behavior, and continued wandering into other apartments uninvited for the month of February could be located.

Additional record review revealed Tenant #1's Unusual Occurrence Report dated 3/22/23, indicated Tenant #1 displayed exit seeking behaviors and exited the building 10-15 times and walked around to the front of the building. Staff attempted to redirect him with no success and he left in the ambulance.

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According to the state climatologist the weather in Davenport on 3/22/23 around 4:00 a.m. was 44 degrees Fahrenheit with relative humidity of 82%, the sky was cloudy and the winds were out of the south at 10 mph with a windchill of 36 degrees.

The Patient Care Report from the responding EMS documented on 3/22/23 they arrived on scene at 3:59 a.m. and observed Tenant #1 walk out of the building then return to the door. They reported staff did not open the door for him until they arrived at the door and asked to be let in.

On 3/23/23 at 10:48 a.m. EMS #1 reported when they arrived she observed Tenant #1 walking out of the building and attempted to go back in the door. She stated she saw four staff inside and no one opened the door for him until they walked up and the staff saw them.

When interviewed on 3/27/23 at 3:53 p.m. EMS #2 stated she observed Tenant #1 leave the building and saw the staff close the door after he left. He walked toward us and when he saw us, walked back to the building and stood by the memory care doors. We pulled up in our vehicle and could see four staff looking at the door. The staff opened the door after we walked up to him by the door.

When interviewed on 3/23/23 at 12:11 p.m. Staff A and Staff B confirmed the behavior observed on 3/23/23 was typical for Tenant #1 and he required constant supervision to prevent him from exiting the unit. Tenant #1 exhibited this behavior since his admission in January. They stated he could read the instructions to hold the bar for fifteen seconds to open the door.

When interviewed on 3/23/23 at 2:16 p.m. Staff C

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A 160	Continued From page 4	A 160		

reported she worked the overnight shift from 3/21/23 to 3/22/23 in the memory care unit. She reported Tenant #1 displayed verbal aggression and called her the "N" word while he paced back and forth in the area and attempted to open the doors several times. She offered him food that he declined to eat. Staff C said around 3 a.m. she used the restroom as he slept and heard the door alarms go. He was not in the area so she called her boss to report what happened instead of going out to look for him. She confirmed he was outside alone until other Program staff arrived to look for the him. She stated the Program provided no training prior to working in the dementia unit and she was unsure what to do.

When interviewed on 3/27/23 7:48 p.m. Staff D stated she worked as the medication aide from 10:00 p.m. to 6:00 a.m. on March 21-22, 2023. She said she went back to memory care at least once before EMS arrived and Staff C called for help because Tenant #1 walked out of the building. Staff C explained Tenant #1 knew how to open the doors because he read the instructions to hold it for 15 seconds. He walked out the east door and walked to the front of the building and then to the west door. Staff E and Staff F went out to look for him. She reported at one time all staff were inside when he was outside. She said her and Staff F were right by the door and observed him outside and Staff E returned inside from the other door. She stated they could see him outside and it was only a few minutes and somebody said the ambulance was here and EMS were standing by the door before I could go open it. She confirmed there was a steep hill behind the building and it was very dark out and he could have easily gotten hurt.

When interviewed on 3/23/23 at 1:42 p.m. Staff F

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A 160	Continued From page 5 confirmed she worked from 10:00 p.m. 3/21/23 to 6:00 a.m. 3/22/23. She said their training included to try and redirect but Tenant #1 liked to hit and she was afraid of being close to him. She commented if he got outside the building she would let him walk out because he would hit staff. When interviewed on 3/27/23 at 3:14 p.m. the Director reported staff expressed fear of Tenant #1 and stated staff should have been in the vicinity of a tenant who exited the building. She confirmed agency staff were not delegated by the Program's nurse. She was not aware agency staff did not have the required elopement and dementia training.	A 160		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record reveiw the Program failed to evaluate the functional,	A 145		

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A 145	Continued From page 6 cognitive, and health status as needed for a significant change in health status. This pertained to 1 of 1 tenants observed with exit seeking behaviors (Tenant #1). Findings follow: Record review on 3/23/23 of Tenant #1's file revealed the following: Progress Notes dated 2/11/23 revealed staff attempted to redirect Tenant #1 from the exit door and he repeatedly punched her in the face. Staff called 911 and he was transported to the emergency room. He returned on 2/13/23 with orders to administer Ativan as needed for behavior. Continued review of progress notes dated 2/24/23 documented he verbally threatened to knock out a staff and was unable to calm down. Staff called 911 and he was transported to the hospital. He returned the same day with orders to increase his dose of Seroquel. Further review noted on 2/25/23 staff were unable to redirect him as he paced throughout the building and he displayed verbal and physical aggression. Staff called 911 and he was taken to the hospital. No functional, cognitive, and health assessments could be located for these changes in health status. On 3/29/23 at 2:33 p.m. the Registered Nurse confirmed these findings.	A 145		
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	A 395		

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A 395	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop an individualized service plan to meet the identified needs of the tenants. This pertained to 1 of 1 tenants observed with exit seeking behaviors (Tenant #1). Findings follow: Record review on 3/23/23 of Tenant #1's file revealed the following: Progress Notes for the month of January 2023 revealed he moved in on 1/9/23. Tenant #1's progress notes documented four incidents of aggression and required a call to 911 once, two attempts to exit the building, and he entered other tenant's apartments uninvited at least four times. Continued review of Progress Notes for the month of February 2023 noted nine incidents of aggression that required a call to 911 on three occasions, three attempts to exit the building, and he continued to enter other apartments uninvited. Progress Notes dated 2/11/23 revealed staff attempted to redirect Tenant #1 from the exit door and he repeatedly punched her in the face. Staff called 911 and he was transported to the emergency room and returned 2/13/23 with orders to administer Ativan as needed for behavior. Continued review of progress notes dated 2/24/23 documented he verbally threatened to knock out a staff and was unable to calm down. Staff called 911 and he was transported to the hospital. Further review noted on 2/25/23 staff were unable to redirect him as he paced throughout the building and he displayed verbal and physical aggression. Staff called 911 and he	A 395		

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A 395	Continued From page 8 was taken to the hospital. Record review of the dispatch report provided by the police department revealed EMS and/or the police department visited the Program once in January and three times in February for concerns related to Tenant #1. Tenant #1's Service Plans dated 1/26/23 and 1/30/23 failed to include the behaviors of aggression, exit seeking, and wandering into other apartments uninvited and interventions to minimize them. Continued record review failed to reveal updated service plans to reflect his ongoing aggression, exit seeking behavior, and continued wandering into other apartments uninvited for the month of February could be located. On 3/29/23 at 2:33 p.m. the Registered Nurse confirmed these findings.	A 395		
A 525	481-69.29(3) Staffing 69.29(3) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population. This REQUIREMENT is not met as evidenced by: Based on interviews the Program failed to consistently ensure all personnel including contract/agency staff were approprately trained to meet the tenant needs. This pertained to 1 of 1 contract staff reviewed (Staff C). Findings follow:	A 525		

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A 525	Continued From page 9 On 3/23/23 at 2:16 p.m. Staff C stated she worked the overnight shift from 3/21/23 to 3/22/23 in the memory care unit. She reported Tenant #1 displayed verbal aggression and called her the "N" word while he paced back and forth in the area and attempted to open the doors several times. She offered him food that he declined to eat. Staff C said at approximately 3:00 a.m. she used the restroom as he slept when she heard the door alarms go. She explained Tenant #1 was not in the area so she called her boss to report what happened instead of going out to look for him. She confirmed he was outside alone until other Program staff arrived to look for the him. She stated the Program provided no training prior to working in the dementia unit and she was unsure what to do. On 3/27/23 at 3:33 p.m. the Assistant Director of the home health agency confirmed Staff C texted her around 12:27 a.m. to report Tenant #1 displayed verbal aggression and set off the door alarms trying to exit. She called the Program Director to follow up. At 3:44 a.m. Staff C called her to report Tenant #1 set off the alarms and left the building while she was in the bathroom and did not say if anyone went after him. The Assistant Director said staff reported to us they were not able to check on the tenants in the memory care due to not having any keys provided to them and an email was sent to the Director to discuss this on 3/21/23. She confirmed their agency provided no training on working with people with dementia or what to do if a person eloped. On 3/27/23 at 3:14 p.m. the Director confirmed the agency staff contacted her regarding their staff not knowing where the keys were located to	A 525		

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A 525	Continued From page 10 unlock the doors to check on tenants during the overnight shift. She stated the doors were kept locked due to Tenant #1 repeatedly going into other's aparments uninvited.	A 525		
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 the Program failed to ensure contract staff completed the required eight hours of dementia training. This pertained to 1 of 1 contract staff reviewed (Staff C). Findings follow: On 3/23/23 at 2:16 p.m. Staff C stated she worked the overnight shift from 3/21/23 to 3/22/23 in the memory care unit. She reported Tenant #1 displayed verbal aggression and called her the "N" word while he paced back and forth in the area. She offered him food that he declined to eat. Staff C said around 3:00 a.m. she used the restroom as he slept and heard the door alarms go. He was not in the area so she called her boss to report what happened instead of going out to look for him. She stated the Program failed to provide her a key to open the doors. The other Program staff arrived to look for the tenant and Emergency Medical Services (EMS) arrived and took him to the hospital. She reported she received no training from the Program prior to	A 545		

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A 545	Continued From page 11 working in the memory care unit. On 3/27/23 at 3:33 p.m. the Assistant Director of the home health agency confirmed their agency provided no training on working with people with dementia or what to do if a person eloped. On 3/27/23 at 3:14 p.m. the Director confirmed the staff provided by the home care agency did not have the required eight hours of dementia training. She stated no training on the Programs policies and procedures for elopement and/or door alarms were provided to agency staff and she assumed the agency provided the training.	A 545		

Plan of Correction

A 160-481.67.3(2) Tenant Rights

Regulatory insufficiency: Program failed to provide adequate and appropriate care, treatment, and services for 1 of 1 tenant observed with exit seeking behaviors. (Tenant #1)

Plan of Correction:

The insufficiency will be corrected as follows:

- Resident has been provided 1:1 care by private duty caregivers
- Resident has established care with neurologist to manage behavioral medications

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

- Executive Director and Director of Health and Wellness have provided education to caregivers on missing resident policy and unwitnessed door alarm policy on 6/14/23
- Executive Director will provide education on Tenant Bill of Rights to caregivers on 6/14/23

The program will monitor performance to ensure compliance as follows:

- Director of Health and Wellness with interview residents and caregivers routinely during assessment process regarding any concerns or issues related to concerns regarding safety or Resident Bill of Rights.

Date deficiency corrected by 6/14/23

A 145 481-69.22(3) Evaluation of Tenant

Regulatory insufficiency: Program failed to evaluate the functional, cognitive, and health status as needed for a significant change in health status. This pertained to 1 of 1 tenants observed with exit seeking behaviors.

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

- Tenant #1 had change of condition assessment on 3/23/23
- Divisional Director of Health and Wellness provided re-education to Director of Health and Wellness on 6/9/23 on service plans and assessments.

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

- Director of Health and Wellness will audit incident reports, communication book, and observe residents for significant changes to initiate evaluations and service plan updates to meet resident's needs and interventions to ensure safety.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Health and Wellness will audit resident records monthly for 2 months and then 2 times per year after.

Date deficiency corrected by 6/14/23

A 395 481-69.26(4)a Service Plans

Regulatory insufficiency: Program failed to develop an individualized service plan to meet the identified needs of the tenants.

Plan of correction:
The insufficiency will be corrected as follows:

- Service plan for tenant one was updated on 3/23/23
- Divisional Director of Health and Wellness provided education on service planning 6/9/23

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

- Health and Wellness Director will review task sheets, communication book, interview caregivers and update service plans as needed to reflect behaviors and current level of care to meet resident needs and interventions to ensure safety.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Health and Wellness will audit resident records at least twice per year during onsite program visits and as needed.

Date deficiency corrected by 6/14/23

A 525 481-69.29(3) Staffing

Regulatory insufficiency: The program failed to consistently ensure all personnel including contract/agency staff were appropriately trained to meet the tenant needs. (staff C)

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

- Contract Staff C has not worked at Bickford of Davenport since occurrence

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

- Director of Health and Wellness will review contract/agency checklist with staff member and have signature of file for compliance.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Operations will audit branch agency file quarterly for checklist signature compliance to agency usage.

Date deficiency corrected by 6/14/23

A 545 481-69.30(1) Dementia Specific Education for Personnel

Regulatory insufficiency: The programed failed to ensure contract staff completed the required eight hours of dementia training. (staff C)

Plan of Correction:

The insufficiency will be corrected as follows:

- Contract staff C has not worked at Bickford of Davenport since occurrence
- Divisional Director of Health and Wellness provided education to Executive Director on 6/8/23 and to Vice President of Bickford Home Care on requirements

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

- Executive Director to request documentation to have on file of 8 hours of dementia training before contract staff is working shift in building.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Operations will audit branch agency use records quarterly for compliance.

Date deficiency corrected by 6/14/23