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 01/22/2025

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 population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 9 Number of tenants with cognitive impairment: 24 Total census: 33 The following regulatory insufficiencies were cited during the investigation into Complaint #125932-C and Complaint #125018-C.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to follow the established policy regarding incident reports for 1 of 1 tenants reviewed with an injury (Tenant #1). Findings follow: Review of an incident report dated 1/13/25 at 8:30 AM revealed Tenant #1 had a bruise to her right posterior thigh. Tenant #1 suggested to her Hospice Certified Nursing Assistant (CNA) the bruise may have occurred as a result of a rape. When the program Health and Wellness Director spoke with Tenant #1 on 1/13/25 about the bruise, the tenant denied any knowledge of where/when/how the bruise was acquired. The	A 150		

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A 150	Continued From page 1 staff who worked the evening shift on 1/12/25 and assisted Tenant #1 several times denied any unusual occurrences during her shift. Tenant #1 reported her leg "getting stuck" when self propelling her wheelchair backwards to her apartment. On 1/16/25 at 8:10 AM, Staff A reported she became aware of a bruise on Tenant #1's right inner thigh on 1/11/25 at 11:00 PM. Staff A assisted Tenant #1 to the toilet and discovered the bruise to her inner thigh. Tenant #1 reported she did not know how she got the injury. Staff A did not document the new bruise because she could not access the program's electronic health record system. A review of the program's Incident and Accident Report policy noted incidents and accidents should be reported and documented immediately after they occur. This would include resident falls, injuries or wounds. Tenant incidents or accidents shall be documented in the Electronic Health Record immediately following the occurrence. The incident shall include statements from individuals, if any, who witnessed the incident. On 1/16/25 at 2:50 PM, the Health and Wellness Director reported Staff A should have entered the information about Tenant #1's skin concern into the Electronic Health Record when it was noted. If she could not access the system, Staff A should have contacted the Health and Wellness Director or the Executive Director.	A 150		
A 150	481-69.23(1)a Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or	A 150		

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A 150	Continued From page 2 retained. A program shall not knowingly admit or retain a tenant who: a. Is bed-bound This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program retained 1 of 1 tenants reviewed who was bed bound (Tenant #5). Findings follow: On 1/16/25 review of Tenant 5's progress notes revealed on 11/8/24 the Health and Wellness Director was unable to review weight trends due to Tenant #5 remaining in bed per preference. She was unsure of the tenant's transfer capacity at the time. Tenant #5 verbalized he'd prefer to not try to get up. A service plan dated 12/4/24 revealed Tenant #5 required full assistance with transfers or was bedridden. His service plan indicated a hospice waiver was submitted in August 2024 for Tenant #5 to allow the program leniency in meeting his needs. On 1/16/25 at 1:20 PM, Staff D stated Tenant #5 was bed bound. Staff provided incontinence cares to him in bed. He ate all his meals in bed. On 1/16/25 at 1:40 PM, Staff E reported Tenant #5 had been in his bed for over three months. Within this period, his hospice bath aide got him out of the bed once for about an hour to sit in his wheelchair. On 1/22/25 at 8:48 AM, the Health and Wellness Director reported the program did not submit a hospice waiver to the Department for Tenant #5.	A 150		

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A 150	Continued From page 3 She confirmed the tenant was bed bound.	A 150		
A 160	481-69.23(1)c(1) 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: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program retained 3 of 7 tenants reviewed who displayed either exit-seeking behavior, verbal or physical aggression despite interventions (Tenant #2, Tenant #6 and Tenant #7). Findings follow: 1) Review of Tenant #2's progress notes on 1/16/25 revealed the following: - On 11/3/24, staff entered Tenant #2's apartment, attempted to get her up and was told the tenant put herself on the floor. Tenant #2 then said she was going to bite staff and cursed at staff. - On 12/8/24, Tenant #2 was verbally aggressive toward other tenants during lunch. She screamed swear words and told other tenants she hated them. Tenant #2 also snatched another tenant's plate from them while they were eating. - On 12/18/24 at 1:28 PM, Tenant #2 yelled "I hate Negroes and I hate Mexicans." At 7:56 PM on the same date, she became combative when	A 160		

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staff were providing toileting assistance. She stated, "I hate you because you're Mexican American." Staff documented Tenant #2 was usually combative with incontinence cares, but she was extremely combative on this date. She pushed staff away, fell on her side and dug her nails into the employee's arm.

- During cares on 1/1/25, Tenant #2 was hitting, biting, kicking and stating "I hate black people, I hate Negroes."
- Tenant #2 was aggressively exit seeking on 1/5/25.
- At supper on 1/7/25, staff sat down with the tenants and asked how the food was. Tenant #2 threw her drink on the staff. When asked why she did that, she reported it was because the employee was Mexican. On 1/7/25 at 9:48 PM, Tenant #2 pulled staff's hair. While attempting to provide incontinence cares, she kicked her legs, grabbed a cup of water and tried to throw it at staff.
- On 1/8/25, the Health and Wellness Director (HWD) directed staff to notify the medication manager and hospice about each episode of aggression. The medication manager was directed to administer a PRN (as needed) anti-anxiety medication and notify hospice if the medication was ineffective.
- On 1/9/25, Tenant #2 got up from the couch and began exit-seeking. The couch she was sitting on was soaked in urine. When staff took her for incontinence cares, she was very combative - biting, kicking and yelling.
- On 1/14/25, Tenant #2 threw her soda on another tenant and her food on staff.

On 1/16/25 at 10:25 AM, Staff F reported Tenant #2 was usually physically aggressive during morning cares. She punched at Staff F and called her racial slurs. Tenant #2 would lay on the couch

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through the day and yell out swear words to the other tenants. Tenant #2 and Tenant #7 got into yelling matches at meal time.

On 1/16/25 at 1:20 PM, Staff D reported Tenant #2 was physically aggressive on a daily basis. She would scratch, bite, kick and curse.

Tenant #2 had a service plan dated 7/15/24 which identified she was physically and verbally aggressive toward staff during routine cares. Staff were to honor her right to refuse cares, provide enhanced interventions due to resistance to care services and provide enhanced interventions and care coordination to de-escalate negative behaviors. Tenant #2's service plan was updated on 10/31/24 when she moved to the program's secured memory care unit. The program retained Tenant #2 despite her displaying ongoing physical and verbal aggression to staff and other tenants.

2) Review of progress notes for Tenant #6 revealed the following:
- Tenant #6 moved to the program's secured memory care unit on 10/8/24. He was noted to have a diagnosis of dementia. Tenant #6's son and daughter noticed a decrease in exit-seeking behaviors once they stopped putting shoes on Tenant #6.
- The program documented Tenant #6 attempted to leave the building on 10/12/24, 10/13/24 and 10/14/24. The program notified his primary care provider (PCP) about his behaviors, exit-seeking and difficulty with redirections, asking for a medication review. New medication orders were received.
- On 10/17/24, Tenant #6 continued his exit-seeking behaviors, such as banging on the exit doors, but also telling others staff were trying to kill him.

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- Tenant #6 was exit-seeking multiple times on 10/18/24. He became combative with staff and the police were called.
- The program notified Tenant #6's medical provider of ongoing concerns with his behaviors, exit-seeking tendencies and physical aggression on 10/22/24.
- The program implemented a new service plan for Tenant #6 on 11/1/24 due to a change of condition in functional status. Tenant #6 was referred for hospice services. Staff were encouraged to promote the tenant's safety, promote repositioning and routine incontinence care. Staff asked his family to provide simple, comfortable clothing for the tenant as he was often removing his clothes.
- On 11/5/24, Tenant #6 grabbed an employee's arms and kicked at her during incontinence cares.
- On 11/10/24, Tenant #6 was combative with staff when trying to leave the building. He swung a walker at staff.
- On 12/4/24, Tenant #6 was aggressive, swearing and would not stop screaming and banging on other tenants' mailboxes.
- Tenant #6 was very agitated on 12/8/24. He wanted to leave the building. He was walking around in only an incontinence brief and refused to put pants on. He became aggressive when asked to put pants on.
- On 1/1/25, Tenant #6 was agitated throughout the day. He was yelling and exit-seeking. Tenant #6 wouldn't stay dressed, wouldn't let staff assist with incontinence cares and yelled at staff to leave him alone along with name calling. Later, staff walked in on Tenant #6 and he was pooping on the floor. He yelled as staff helped with the cleaning process.
- The HWD documented on 1/2/25 a call was placed to Tenant #6's Power of Attorney to notify

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her of concerns with Tenant #6's behaviors and resistance to cares.
- On 1/7/25, staff heard a tenant yelling, help me, he's in my bed. Tenant #6 was fully undressed in another tenant's bed. He became very agitated and refused to leave the apartment, convinced he was in the correct room.
- On 1/8/25, Tenant #6 wandered into other tenant's rooms. When approached, he would tell staff to leave him alone and cursed at staff.

On 1/16/25 at 1:40 PM, Staff E said Tenant #6 was often undressed. He would become physical when staff attempted to get him dressed or when they directed him away from the exit doors.

On 1/16/25 at 10:26 AM, Staff F stated Tenant #6 had anger issues and would hit out at others.

Tenant #6 had a service plan dated 11/1/24 which included interventions to address his exit-seeking and aggression. Despite these interventions, he continued to display physical aggression toward staff.

3) Review of Tenant #7's progress notes revealed the following entries:
- On 9/1/24, Tenant #7 was yelling you Son of a Bitch (SOB) and asking for help. When staff brought her to the dining room to be with staff and the other tenants, she yelled continuously. The yelling continued when she was back in her room.
- On 10/18/24, Tenant #7 screamed at staff when they attempted to change her soiled sheets.
- On 11/16/24, Tenant #7 was unhappy to be out of her room while staff shampooed her carpet. She screamed throughout the process, slid out of her wheelchair multiple times and continuously called staff a dumb SOB.
- On 11/17/24, Tenant #7 was in the living room

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yelling at other tenants calling them SOBs.
- On 11/18/24, Tenant #7 was yelling in her room so staff brought her to the living room. She then started yelling at other tenants and staff and calling them names.
- On 12/8/24, Tenant #7 was at the dinner table when she grabbed her plate and drink and threw them making a mess. She called others' names and then grabbed more items and threw them.

On 1/16/25 at 10:26 AM, Staff F reported Tenant #7 refused to get out of bed but will yell for help throughout the day. When staff entered her room and asked what she wanted, Tenant #7 did not know what she needed/wanted.

On 1/16/25 at 1:40 PM, Staff E said Tenant #7 repeatedly curses and yells "help" and "you stupid SOB" which is aggravating for the tenants in the secured memory care unit. When she is asked what she wants the tenant does not know. Then, the tenant starts yelling again.

On 1/16/25 at 1:20 PM, Staff D stated Tenant #7 wasn't physically aggressive, but she screamed a lot.

Tenant #7 had a service plan dated 8/26/24 which addressed her behaviors. Caregivers were to be aware Tenant #7 had severe cognitive deficits and her disease process caused her to experience routine verbal inappropriateness which was a symptom of her disease. Caregivers were to ignore these statement. She was routinely saying things such as "You stupid son of a bitch" and "You people are good for nothing idiots." he awful, repetitive statements were out of her control. Staff should not scold her for the vulgarity or engage with the negative statements.

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A 160	Continued From page 9 4) Although interventions were included in their service plans, the program retained tenants who continued to display verbal aggression, physical aggression or attempts at elopement (exit seeking) behaviors. The Health and Wellness Director confirmed these findings on 1/16/25 at 2:50 PM.	A 160		