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 06/19/2024

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. Number of tenants without cognitive impairment: 14 Number of tenants with cognitive impairment: 11 Total census: 25 There were no regulatory insufficiencies cited during the investigation into Complaint #117601-C, Complaint #119817-C and Complaint #120048-C. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program for People with Dementia.	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 135		

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

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 06/19/2024

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 135	Continued From page 1 a scored cognitive screening tool. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to conduct health assessments prior to admission for 2 of 2 tenants reviewed admitted since March, 2024 (Tenant #2 and Tenant #3). Findings follow: Record review on 6/18/24 of a facesheet for Tenant #2 revealed he moved in on 3/26/24. The Health and Wellness Director completed the Mini-Mental State Examination and a Resident Assessment for Tenant #2 on 3/26/24. The Resident Assessment addressed Tenant #2's functional needs but did not include a health evaluation. Tenant #3's face sheet noted he moved to the program on 5/15/24. A Mini-Mental Sate Examination and a Resident Assessment were completed on 5/16/24 (the day after he moved to the program). The Resident Assessment did not include an evaluation of Tenant #3's health needs. The Health and Wellness Director confirmed this finding on 6/18/24 at 1:25 PM.	A 135		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. 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	A 140		

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 06/19/2024

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 140	Continued From page 2 exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to evaluate the health condition within 30-days of admission for 2 of 2 tenants admitted since March 2024 (Tenant #2 and Tenant #3). Findings follow: Record review on 6/18/24 revealed Tenant #2 moved to the program on 3/26/24. The Health and Wellness Director completed a Resident Assessment and a cognitive evaluation for Tenant #2 on 4/25/24. This did not include an evaluation of Tenant #2's health. Tenant #3's face sheet identified he moved to the program on 5/15/24. The Health and Wellness Director completed a Resident Assessment and cognitive evaluation for Tenant #3 on 5/24/24. She did not evaluate his health needs within 30-days of his admission. The Health and Wellness Director confirmed this finding on 6/18/24 at 1:25 PM.	A 140		
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	A 145		

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 06/19/2024

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 145	Continued From page 3	A 145		

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 review, the program failed to evaluate tenant health status annually or with a significant change for 2 of 4 current tenants reviewed (Tenant #1 and Tenant #4). Findings follow:

1) Record review on 6/18/24 of progress notes for Tenant #1 revealed the Health and Wellness Director documented the tenant experienced an ongoing overall decline in her health and functional status. Tenant #1 was no longer able to walk without assistance and experienced routine urinary incontinence. Tenant #1 began receiving hospice services on 6/3/24.

The Health and Wellness Director completed a cognitive evaluation and a Resident Assessment for Tenant #2 on 6/3/24. There was no an evaluation of her health needs.

2) Progress notes for Tenant #4 identified he experienced a change in condition related to his diet on 5/1/24. The Health and Wellness Director updated Tenant #4's assessments at that time.

A review of the assessments for Tenant #4 revealed the Health and Wellness Director completed a cognitive evaluation and a Resident Assessment. There was no evaluation of Tenant

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 06/19/2024

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 145	Continued From page 4 #4's health. On 6/18/24 at 1:45 PM, the Health and Wellness Director confirmed this finding.	A 145		
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 tenants routinely requiring the assistance of two staff for transfers. This pertained to 1 of 4 tenants reviewed (Tenant #4). Findings follow: Record review on 6/18/24 revealed a service plan for Tenant #4 dated 5/1/24. Tenant #4's service plan identified he required full assistance with all aspects of bathroom activities and hygiene. He required two people to assist him with toileting. Tenant #4 was incontinent of the bowel and bladder. Tenant #4 required full, hands-on assistance with mobility. Tenant #4 used a wheelchair and intermittently required two staff to assist him with a gait belt for transfers. On 6/18/24 at 11:10 AM, Staff B stated Tenant #4 required two people to assist him with transfers. He was largely bed-bound and did not like to get out of bed.	A 155		

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 06/19/2024

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 155	Continued From page 5 On 6/18/24 at 11:40 AM, Staff C stated she was physically able to transfer Tenant #4 on her own. However, Tenant #4 and his wife preferred two people were present for transfers due to his anxiety level. On 6/18/24 at 1:25 PM, the Health and Wellness Director reported most of the time they were using 2 people to transfer Tenant #4. He had a catheter which made transfers trickier. Tenant #4 also experienced anxiety which meant it was easier, safer and quicker to transfer Tenant #4 with the assistance of two staff. In the month of June, 2024, Tenant #4 was a 2-person assist over half the time.	A 155		
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 observation, interview and record review, the program retained a tenant who displayed unmanageable aggression. This pertained to 1 of 1 tenant admitted since March 2024 who displayed physical aggression (Tenant #3). Findings include:	A 160		

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 06/19/2024

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 160	Continued From page 6	A 160		

Observations on the memory care unit on 6/17/24 at 3:49 PM revealed Tenant #3 pushed on an exit door and left the building. Staff witnessed this and followed him out of the building, leaving two other tenants without staff present for approximately two minutes.

Record review on 6/18/24 of Physician's Orders for Tenant #3 revealed he moved to the program on 5/15/24. Tenant #3 carried diagnoses of agitation, cerebrovascular disease and early onset dementia. The program documented the following incidents for Tenant #3 in the Notes portion of his record:

- On 5/19/24, Tenant #3 threw a big jar of sour cream at staff.

- On 5/20/24, Tenant #3 had a restless weekend. On 5/18/24, Tenant #3 was combative and agitated toward staff.

- During the overnight shift from 5/20/24 - 5/21/24, Tenant #3 was restless. Staff administered oral and topical medication to Tenant #3 to try and manage his anxiety. Tenant #3 sat in a recliner and when staff went to prop up his recliner, the tenant grabbed her wrist with both hands and tried to break it. Staff pulled away and Tenant #3 kicked her three times in the knee and shin.

- A care meeting held on 5/21/24 included discussion of Tenant #3's behaviors with his wife and hospice provider and the need for medication adjustments. Tenant #3 had an increase in hydroxyzine. It was noted Tenant #3 may experience pain and staff could administer PRN (as needed) morphine when he was experiencing

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 06/19/2024

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 160	Continued From page 7	A 160		

restlessness or insomnia. Additional medication changes were made as well as adding interventions for staff, such as providing him with preferred snacks.

- The program updated Tenant #3's service plan on 5/22/24 to address his aggressive behaviors and exit-seeking activity.

- On 5/23/24, staff was seated while Tenant #3 paced nearby. Tenant #3 pulled back his fist and acted as if he would punch her.

- On 5/24/24, caregivers were in the courtyard with Tenant #3 and another tenant blowing bubbles. Tenant #3 seemed to enjoy the activity at first but became angry and punched a caregiver in the face with a closed fist. He then hit and shoved her. Another caregiver intervened and he hit this person in the back. Tenant #3's wife agreed to provide 1:1 companionship. Additional medication adjustments were put in place.

- On 6/5/24, Tenant #3 became upset when staff escorted him out of another tenant's room. Tenant #3 grabbed the staff member's arms and shoved her out of the way. He continued banging on other tenants' doors for 45 minutes.

- On 6/5/24, Tenant #3 was attempting to exit the memory care unit. Staff attempted to redirect Tenant #3 and he then started hitting staff in the head. Tenant #3 pinned the staff on the ground. Another employee came to the unit and gave Tenant #3 PRN medication.

- Tenant #3 became angry when staff tried to redirect him out of the kitchen on 6/8/24 and kicked her in the chest.

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 06/19/2024

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 160	Continued From page 8 Tenant #3's service plan, dated 5/24/24, identified he was verbally disruptive (yelling, argumentative and had angry outbursts) and physically disruptive (pushing, biting, throwing or hitting). The plan included interventions such as speak in a calm and reassuring manner, call him by his nickname and remind him his wife wants him to relax. Staff were to offer PRN medication. They were not to argue with Tenant #3 as it would irritate him. On 6/17/24 at 3:52 PM, Staff A reported Tenant #3 would try to leave the building, especially in the evening and afternoon. Staff A recalled when Tenant #3 first moved to the program, he tried to climb over the fence which was around the courtyard. Tenant #3 attempted to leave the building throughout the day. On 6/18/24 at 1:25 PM, the Health and Wellness Director confirmed Tenant #3 displayed exit-seeking behaviors as well as physical aggression in spite of program-initiated interventions.	A 160		

A135 481-69.22(1) Evaluation of Tenant

Regulatory Insufficiency: The program failed to conduct health assessments prior to admission.

Plan of Correction:

The insufficiency will be corrected as follows:

- Tenant #2 entered end of life stage and per family wishes discharged to home on 9/6/24.
- Tenant #3 health evaluation was completed on 9/5/24.

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

- Executive Director re-educated Health & Wellness Director on requirements of health evaluation prior to move in.

The program will monitor performance to ensure compliance as follows:

- Executive Director or designee will review all new admission resident assessments for 60 days to ensure a health assessment is included.

Date deficiencies corrected by: 09/06/24

A140 481-69.22(2) Evaluation of Tenant

Regulatory Insufficiency: The program failed to conduct health assessments within 30 days of occupancy.

Plan of Correction:

The insufficiency will be corrected as follows:

- Tenant #2 entered end of life stage and per family wishes discharged to home on 9/6/24.
- Tenant #3 health evaluation was completed on 9/5/24.

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

- Executive Director re-educated Health & Wellness Director on requirements of health evaluation within 30 days of occupancy

The program will monitor performance to ensure compliance as follows:

- Executive Director or designee will review all new admission resident assessments for 60 days to ensure a health assessment is included.

- **Date deficiencies corrected by:** 09/06/24

A145 481-69.22(3) Evaluation of Tenant

Regulatory Insufficiency: The program failed to evaluate tenant health status annually or with significant change.

Plan of Correction:

The insufficiency will be corrected as follows:

- Tenant #1 expired on 6/15/24.
- Tenant #4 health evaluation was completed on 9/6/24.

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

- Executive Director re-educated Health & Wellness Director on requirements of health evaluation requirements annually and with significant change.

The program will monitor performance to ensure compliance as follows:

- Executive Director or designee will review all annual or significant change of condition resident assessments for 60 days to ensure a health assessment is included.

Date deficiencies corrected by: 09/06/24

A155 481-69.23 (1)b Criteria for Admission/Retention of tenants

Regulatory Insufficiency: The program retained tenants routinely requiring the assistance of two staff for transfers.

Plan of Correction:

The insufficiency will be corrected as follows:

- State Waiver completed for Tenant #4 and sent to DIA on 9/6/24.

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

- Executive Director or Health and Wellness Director will complete an all-staff in-service on criteria for admission/retention of tenants by September 25, 2024.
- Executive Director or designee will review current resident service compliance with criteria for admission/retention of tenants as outlined in chapter 69 by September 15, 2024.

The program will monitor performance to ensure compliance as follows:

- Executive Director or designee will randomly audit resident service plans for 60 days to ensure program follows criteria for admission/retention of tenants as outlined in chapter 69.

Date deficiencies corrected by: 09/06/24

A160 481-69.23 (1)c(1) Criteria for Admission/Retention of tenants

Regulatory Insufficiency: The program retained a tenant who displayed unmanageable aggression.

Plan of Correction:

The insufficiency will be corrected as follows:

- Tenant #2 entered end of life stage and per family wishes discharged to home on 9/6/24.

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

- Executive Director or Health and Wellness Director will complete an all-staff in-service on criteria for admission/retention of tenants by September 25, 2024.
- Executive Director or designee will review current resident service compliance with criteria for admission/retention of tenants as outlined in chapter 69 by September 15, 2024.

The program will monitor performance to ensure compliance as follows:

- Executive Director or designee will randomly audit resident service plans for 60 days to ensure program follows criteria for admission/retention of tenants as outlined in chapter 69.

Date deficiencies corrected by: 09/06/24