

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2021
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BICKFORD COTTAGE MARION**1100 LINDEN DR
MARION, IA 52302**

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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. General Population Number of tenants without cognitive disorder: 22 Number of tenants with cognitive disorder: 2 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 7 TOTAL Census of Assisted Living Program for People with Dementia: 31 An onsite infection control survey was completed from 2-17-21 to 3-4-21. There were no regulatory insufficiencies identified. Comments were made to the Program regarding guidance recommended for personal protective equipment and screening. The following regulatory insufficiencies were cited during the investigation of Complaint #92042-C:	A 000	See Attached POC 5/18/21	
A 105	481-67.2 Program Policies and Procedures 481-67.2 Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.	A 105		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 105	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to establish an accident and emergency response policy that included provisions for head injuries. This pertained to 3 of 4 tenants reviewed (Tenants #1, #2 and #4). It potentially affected all tenants (census of 31). Findings follow:</p> <ol style="list-style-type: none"> Record review on 2-21-21 of Tenant #1's file revealed an Unusual Occurrence Report dated 5-8-20 indicated staff was in the common area with Tenant #1. Staff looked away briefly and Tenant #1 was on the floor. He hit his head on the piano and there was a laceration on the back of his head approximately two inches in length. It was bleeding and appeared Tenant #1 needed stitches. Tenant #1 was sent to the hospital and received five staples in the back of his head. Record review on 2-21-21 of Tenant #2's file revealed diagnoses included: paroxysmal atrial fibrillation. Tenant #2 was prescribed an anti-coagulant (Xarelto 20 milligram, one tablet every morning). An Unusual Occurrence Report dated 6-22-20 indicated Tenant #2 was found on the floor. He had apparently reached for something, rolled out of his chair and was on the floor. Tenant #2 could not bear weight to stand up, made a clicking noise with his jaw and was biting his tongue. The report noted Tenant #2 seemed confused. Tenant #2 was sent out via a non-emergent ambulance. <p>Continued record review of hospital records dated 6-22-20 indicated Tenant #2 rolled out of his chair at the Program and did not sustain any obvious injuries. Later, staff assisted him up to use the bathroom and he was unable to walk. Tenant #2</p>	A 105		

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A 105	<p>Continued From page 2</p> <p>did not have any motor function in his bilateral lower extremities and chewed his lips. Emergency medical services (EMS) was activated and Tenant #2 was transported to the hospital for evaluation and treatment. EMS noted Tenant #2 had left neglect. In the emergency room it was noted his platelet count was 0 and international normalized ratio (INR) was 1.6. Hospital problems indicated included: intracerebral hemorrhages, thromocytopenia, subarachnoid hemorrhage, a subtherapeutic INR and complete heart block (chronic). It was indicated it was not a survivable event due to the lack of platelets (0 platelets), the extent of hemorrhaging and multiple comorbidities. Tenant #2 was admitted to the medical floor with comfort cares and would be transferred to hospice in the morning.</p> <p>3. Record review on 2-21-21 of Tenant #4's file revealed an Unusual Occurrence Report dated 12-17-20 indicated staff found Tenant #4 on the floor, face down. Tenant #4 sustained a minor skin injury and pain and the site of the injury was indicated as her head. An Unusual Occurrence Report dated 12-24-20 indicated staff walked by Tenant #4's apartment and noticed her on the floor, she was bleeding from her face and had a bump on her forehead.</p> <p>4. Continued record review of the Program's Incident and Accident Report policy indicated tenant, staff and visitor accidents or incidents were reported and documented immediately after they occurred. Incidents were reported to the nurse or director. The incidents were documented on an Incident Report Form immediately following the incident. The incident was also documented in Resident Progress Notes. Staff completed the top portion of the Fall</p>	A 105		

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A 105	<p>Continued From page 3</p> <p>Investigation Tool immediately after the fall. The nurse completed the bottom portion of the form within 24 hours or the next business day. Vital signs were documented on the report. The reports were submitted to the director or nurse for review.</p> <p>The Program's Incident and Accident Report policy provided did not reveal any provisions for head injuries.</p> <p>5. When interviewed on 3-4-21 at 9:55 a.m. the Director confirmed there was a not a separate policy for head injuries. In an email sent on 3-4-21, the Director confirmed there was not a head injury policy;however, it was treated through nurse delegation and provided a nurse delegation training form used for staff.</p>	A 105		
A 145	<p>481-69.22(3) Evaluation of Tenant</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the</p>	A 145		

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A 145	<p>Continued From page 4</p> <p>Program failed to complete evaluations as needed with significant change. This pertained to 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow:</p> <p>1. Record review on 2-22-21 of Tenant #1's file revealed Tenant #1 was admitted on 3-3-20 and discharged on 6-4-20. Diagnoses included: psychosis and Parkinson's disease. A Weight and Vitals Record documented Tenant #1 had a 24 pound weight loss from 3-5-20 to 5-4-20.</p> <p>Continued record review revealed faxes to the physician indicated the following:</p> <p>a. A fax dated 4-7-20 indicated Tenant #1 opened the window, punched and kicked out the screen and climbed through the window. Staff attempted to redirect him to stay inside. A nurse went outside as he climbed through the window and walked with him until local law enforcement could assist. Tenant #1 returned to the building with an officer.</p> <p>b. A fax dated 4-13-20 indicated Tenant #1 attempted to go into the medication room, staff went to shut the door and he pushed her into the counter and used a closed fist to hit her in the stomach. Tenant #1 paced, swore and got into staffs' faces. At approximately 6:30 p.m. he "purposely" had a bowel movement on the dining room floor. The fax indicated Tenant #1 had been going into other tenant apartments looking for a way out.</p> <p>c. A fax dated 4-20-20 indicated Tenant #1 was angry staff when told him he could not leave. He removed two to three glasses and smashed them on the ground.</p>	A 145		

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A 145	<p>Continued From page 5</p> <p>d. A fax dated 5-4-20 indicated Tenant #1 had started urinating in random places around the building, including other tenant apartments. He was going into other tenant apartments at all times of the day. Tenant #1 was not eating well, would eat maybe one full meal per day and some days, just bites.</p> <p>e. A fax to the physician dated 5-13-20 indicated some of the tenants had become fearful of him coming into their apartments and in one instance he got into a female tenant's bed.</p> <p>Further record review revealed Unusual Occurrence Reports reflected falls on 3-25-20, 4-1-20, 4-18-20, 4-21-20, 5-3-20, 5-8-20, 5-11-20, and 5-13-20, including two reports where Tenant #1 was sent to the hospital (5-8-20 and 5-13-20). The Unusual Occurrence Report dated 5-8-20 indicated staff was in the common area with Tenant #1. Staff looked away briefly and Tenant #1 was on the floor. He hit his head on the piano and there was a laceration on the back of his head approximately two inches in length. It was bleeding and appeared Tenant #1 needed stitches. Tenant #1 was sent to the hospital and received five staples in the back of his head. The Unusual Occurrence report dated 5-13-20 reflected Tenant #1 was found lying on the floor and he complained of severe shoulder pain. Staff did not get him up, called an ambulance and he was sent to the hospital.</p> <p>Evaluations were completed for Tenant #1 on 4-1-20 (30 days evaluations). Evaluations were not completed with significant change, including with Tenant #1's weight loss, behaviors and falls.</p> <p>2. Record review on 2-22-21 of Tenant #2's file</p>	A 145		

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A 145	<p>Continued From page 6</p> <p>revealed diagnoses included: paroxysmal atrial fibrillation. Tenant #2 was prescribed an anti-coagulant (Xarelto 20 milligram, one tablet every morning). A Weights and Vitals Record indicated Tenant #2 a 24 pound weight loss from 1-3-20 to 6-3-20.</p> <p>Continued record review revealed Progress Notes indicated the following:</p> <p>a. On 6-4-20 (late entry) notes indicated an order was received on 6-1-20 for physical therapy (PT) to evaluate and treat.</p> <p>b. On 6-15-20 notes indicated nursing services were added (to outside services) to assist with skin breakdown.</p> <p>c. On 6-22-20 notes indicated over the weekend Tenant #2's "bottom" developed an area of bleeding. It appeared that he scratched that area often and had complaints of itching. It would be discussed with the home health nurse. A new purple spot type rash was observed all over his body, however, concentrated on his lower extremities, more than other areas.</p> <p>d. On 6-23-20 notes indicated Tenant #2 was found on the floor by his recliner at 4:30 p.m. It appeared Tenant #2 was reaching and rolled out of the chair. Tenant #2 could not bear weight and was more confused. Tenant #2 was transported to the hospital via non-emergent ambulance.</p> <p>e. On 6-23-20 notes indicated Tenant #2 was being transferred to a hospice house with orders for end of life care.</p> <p>Further record review revealed faxes to the physician indicated the following:</p>	A 145		

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A 145	<p>Continued From page 7</p> <p>a. A fax dated 4-13-20 indicated Tenant #2' scrotum and rectum were reddened and itched. He had a barrier cream ordered twice daily that was frequently refused. An order was received for Venelex to scrotum and perineal area twice daily.</p> <p>b. A fax dated 5-11-20 indicated Tenant #2's "bottom" was worse again and it was noted to have almost a fungal appearance. He had a few open areas that could have been from scratching. Tenant #2 did not get out of his chair unless asked to do so. Tenant #2 was encouraged to go for two walks per day and the service plan was going to be changed to reflect increased assistance with toileting. Orders were received for Fluconazole 100 mg, orally, for 7 days and Venelex, apply three times per day, for four weeks.</p> <p>c. A fax dated 5-27-20 indicated Tenant #2 had a steady decline in his weight. It also noted Tenant #2's "bottom" was not improving and it was the two week point of the increased Venelex.</p> <p>d. A fax dated 6-15-20 indicated Tenant #2's "bottom" was flaking off skin and it was raw underneath. It was requested to have skilled nursing (outside agency) get involved. An order was received for the request.</p> <p>April, May and June 2020 medication administration records (MARs) reflected Tenant #2 routinely refused Venelex ointment treatment (apply topically to to affected area).</p> <p>Evaluations were completed on 5-11-20. Evaluations were not completed as needed with PT services, weight loss, skilled nursing services</p>	A 145		

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A 145	<p>Continued From page 8</p> <p>(outside agency) to assist with skin breakdown, skin issues (including rash) and refusal of services.</p> <p>3. Record review on 2-22-21 of Tenant #3's file revealed diagnoses included: diabetes mellitus. Progress Notes dated 2-4-21 reflected Tenant #3 would return from the hospital that day and an had order for zinc oxide ointment to coccyx, buttocks and gluteal fold, three times per day for 10 days.</p> <p>Evaluations were completed on 2-10-21 (six days post hospitalization) and the evaluations did not reflect the skin issue for Tenant #3 or the treatment to the area.</p> <p>4. Record review on 2-21-21 of Tenant #4's file revealed Tenant #4 received hospice services.</p> <p>When interviewed on 2-22-21 at 2:10 p.m. Staff A indicated Tenant #4 was not getting out of bed and estimated it had been for about a month. Staff provided incontinence cares for Tenant #4 in bed every two hours. Staff attempted to give her sips of water, she had a pureed diet and people assisted her with eating. Staff also repositioned Tenant #4 every two hours.</p> <p>When interviewed on 3-2-21 at 3:33 p.m. Staff B indicated Tenant #4 was not getting out of bed and cares were completed in bed.</p> <p>When interviewed on 3-3-21 at 1:31 p.m. the Nurse indicated Tenant #4 was not getting out of bed. Fluids were offered to Tenant #4 and hospice and family assisted with her meals (pureed diet). Staff completed incontinence</p>	A 145		

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A 145	<p>Continued From page 9</p> <p>cares and repositioned her every two hours. Hospice helped with bathing (bed baths). Tenant #4 had been at that level of care for a little over a month. She was in process of updating the evaluations and service plans and applying for a waiver for Tenant #4.</p> <p>When interviewed on on 2-23-21 at 2:23 p.m. the Director indicated Tenant #4 was in bed all of the time now.</p> <p>Continued record review revealed Progress Notes indicated the following:</p> <p>a. On 2-2-21 notes indicated Tenant #4 had been sleeping more and could not stand well. The hospice nurse believed Tenant #4 was starting to transition to end of life.</p> <p>b. On 2-3-21 notes indicated a new order was received for a pureed diet.</p> <p>Evaluations were completed on 12-7-20 and were not updated with significant change to include Tenant #4's bed bound status and changes with cares including: bed baths, incontinence cares in bed, repositioning, hydration, eating assistance and a diet change.</p> <p>5. When interviewed on 3-3-21 at 1:31 p.m. the Nurse confirmed the evaluations indicated above were the most current evaluations completed for the tenants reviewed. She was in process of updating the evaluations for Tenant #4.</p>	A 145		
A 360	<p>481-69.26(3) Service Plans</p> <p>69.26(3) When a tenant needs personal care or</p>	A 360		

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A 360	<p>Continued From page 10</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed with significant change. This pertained to 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow:</p> <p>1. Record review on 2-22-21 of Tenant #1's file revealed Tenant #1 was admitted on 3-3-20 and discharged on 6-4-20. Diagnoses included: psychosis and Parkinson's disease. A Weight and Vitals Record documented Tenant #1 had a 24 pound weight loss from 3-5-20 to 5-4-20.</p> <p>Continued record review revealed faxes to the physician indicated the following:</p> <p>a. A fax dated 4-7-20 indicated Tenant #1 opened the window, punched and kicked out the screen and climbed through the window. Staff attempted to redirect him to stay inside. A nurse went outside as he climbed through the window and walked with him until local law enforcement could assist. Tenant #1 returned to the building with an officer.</p> <p>b. A fax dated 4-13-20 indicated Tenant #1 attempted to go into the medication room, staff went to shut the door and he pushed her into the counter and used a closed fist to hit her in the stomach. Tenant #1 paced, swore and got into staffs' faces. At approximately 6:30 p.m. he "purposely" had a bowel movement on the dining</p>	A 360		

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A 360	<p>Continued From page 11</p> <p>room floor. The fax indicated Tenant #1 had been going into other tenant apartments looking for a way out.</p> <p>c. A fax dated 4-20-20 indicated Tenant #1 was angry staff when told him he could not leave. He removed two to three glasses and smashed them on the ground.</p> <p>d. A fax dated 5-4-20 indicated Tenant #1 had started urinating in random places around the building, including other tenant apartments. He was going into other tenant apartments at all times of the day. Tenant #1 was not eating well, would eat maybe one full meal per day and some days, just bites.</p> <p>e. A fax to the physician dated 5-13-20 indicated some of the tenants had become fearful of him coming into their apartments and in one instance he got into a female tenant's bed.</p> <p>Further record review revealed Unusual Occurrence Reports reflected falls on 3-25-20, 4-1-20, 4-18-20, 4-21-20, 5-3-20, 5-8-20, 5-11-20, and 5-13-20, including two reports where Tenant #1 was sent to the hospital (5-8-20 and 5-13-20). The Unusual Occurrence Report dated 5-8-20 indicated staff was in the common area with Tenant #1. Staff looked away briefly and Tenant #1 was on the floor. He hit his head on the piano and there was a laceration on the back of his head approximately two inches in length. It was bleeding and appeared Tenant #1 needed stitches. Tenant #1 was sent to the hospital and received five staples in the back of his head. The Unusual Occurrence report dated 5-13-20 reflected Tenant #1 was found lying on the floor and he complained of severe shoulder pain. Staff did not get him up, called an ambulance and he</p>	A 360		

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A 360	<p>Continued From page 12</p> <p>was sent to the hospital.</p> <p>Tenant #1's service plan was dated 4-1-20 (30 day service plan). The service plan was not updated as needed with significant change with Tenant #1's weight loss, behaviors and falls with interventions.</p> <p>2. Record review on 2-22-21 of Tenant #2's file revealed diagnoses included: paroxysmal atrial fibrillation. Tenant #2 was prescribed an anti-coagulant (Xarelto 20 milligram, one tablet every morning). A Weights and Vitals Record indicated Tenant #2 a 24 pound weight loss from 1-3-20 to 6-3-20.</p> <p>Continued record review revealed Progress Notes indicated the following:</p> <p>a. On 6-4-20 (late entry) notes indicated an order was received on 6-1-20 for physical therapy (PT) to evaluate and treat.</p> <p>b. On 6-15-20 notes indicated nursing services were added (to outside services) to assist with skin breakdown.</p> <p>c. On 6-22-20 notes indicated over the weekend Tenant #2's "bottom" developed an area of bleeding. It appeared that he scratched that area often and had complaints of itching. It would be discussed with the home health nurse. A new purple spot type rash was observed all over his body, however, concentrated on his lower extremities, more than other areas.</p> <p>d. On 6-23-20 notes indicated Tenant #2 was found on the floor by his recliner at 4:30 p.m. It appeared Tenant #2 was reaching and rolled out</p>	A 360		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2021
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NAME OF PROVIDER OR SUPPLIER BICKFORD COTTAGE MARION	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 LINDEN DR MARION, IA 52302
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A 360	<p>Continued From page 13</p> <p>of the chair. Tenant #2 could not bear weight and was more confused. Tenant #2 was transported to the hospital via non-emergent ambulance.</p> <p>e. On 6-23-20 notes indicated Tenant #2 was being transferred to a hospice house with orders for end of life care.</p> <p>Further record review revealed faxes to the physician indicated the following:</p> <p>a. A fax dated 4-13-20 indicated Tenant #2' scrotum and rectum were reddened and itched. He had a barrier cream ordered twice daily that was frequently refused. An order was received for Venelex to scrotum and perineal area twice daily.</p> <p>b. A fax dated 5-11-20 indicated Tenant #2's "bottom" was worse again and it was noted to have almost a fungal appearance. He had a few open areas that could have been from scratching. Tenant #2 did not get out of his chair unless asked to do so. Tenant #2 was encouraged to go for two walks per day and the service plan was going to be changed to reflect increased assistance with toileting. Orders were received for Fluconazole 100 mg, orally, for 7 days and Venelex, apply three times per day, for four weeks.</p> <p>c. A fax dated 5-27-20 indicated Tenant #2 had a steady decline in his weight. It also noted Tenant #2's "bottom" was not improving and it was the two week point of the increased Venelex.</p> <p>d. A fax dated 6-15-20 indicated Tenant #2's "bottom" was flaking off skin and it was raw underneath. It was requested to have skilled nursing (outside agency) get involved. An order</p>	A 360		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2021
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A 360	<p>Continued From page 14</p> <p>was received for the request.</p> <p>April, May and June 2020 medication administration records (MARs) reflected Tenant #2 routinely refused Venelex ointment treatment (apply topically to to affected area).</p> <p>Tenant #2's service plan was dated 5-11-20. The service plan reflected he had a cream applied to his "bottom" for protection. The service plan was not updated as needed with PT services, weight loss, skilled nursing services (outside agency) for treatment of skin breakdown, skin issues (including rash) and treatments and refusal of services.</p> <p>3. Record review on 2-22-21 of Tenant #3's file revealed diagnoses included: diabetes mellitus. Progress Notes dated 2-4-21 reflected Tenant #3 would return from the hospital that day and an had order for zinc oxide ointment to coccyx, buttocks and gluteal fold, three times per day for 10 days.</p> <p>Tenant #3's service plan was updated on 2-10-21 (six days post hospitalization) and did not reflect the skin issue and treatment.</p> <p>4. Record review on 2-21-21 of Tenant #4's file revealed Tenant #4 received hospice services.</p> <p>When interviewed on 2-22-21 at 2:10 p.m. Staff A indicated Tenant #4 was not getting out of bed and estimated it had been for about a month. Staff provided incontinence cares for Tenant #4 in bed every two hours. Staff attempted to give her sips of water, she had a pureed diet and people assisted her with eating. Staff also repositioned</p>	A 360		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2021
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A 360	<p>Continued From page 15</p> <p>Tenant #4 every two hours.</p> <p>When interviewed on 3-2-21 at 3:33 p.m. Staff B indicated Tenant #4 was not getting out of bed and cares were completed in bed.</p> <p>When interviewed on 3-3-21 at 1:31 p.m. the Nurse indicated Tenant #4 was not getting out of bed. Fluids were offered to Tenant #4 and hospice and family assisted with her meals (pureed diet). Staff completed incontinence cares and repositioned her every two hours. Hospice helped with bathing (bed baths). Tenant #4 had been at that level of care for a little over a month. She was in process of updating the evaluations and service plans and applying for a waiver for Tenant #4.</p> <p>When interviewed on on 2-23-21 at 2:23 p.m. the Director indicated Tenant #4 was in bed all of the time now.</p> <p>Continued record review revealed Progress Notes indicated the following:</p> <p>a. On 2-2-21 notes indicated Tenant #4 had been sleeping more and could not stand well. The hospice nurse believed Tenant #4 was starting to transition to end of life.</p> <p>b. On 2-3-21 notes indicated a new order was received for a pureed diet.</p> <p>Tenant #4's service plan was completed on 12-7-20 and was not updated with significant change to include Tenant #4's bed bound status and changes with cares including: bed baths, incontinence cares in bed, repositioning, hydration, eating assistance and diet change.</p>	A 360		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2021
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A 360	Continued From page 16 5. When interviewed on 3-3-21 at 1:31 p.m. the Nurse confirmed the service plans indicated above were the most current service plans completed for the tenants reviewed. She was in process of updating the service plan for Tenant #4.	A 360		

**Plan of Correction
Marion Bickford Cottage**

A 105—481-67.2 Program Policies and Procedures

Regulatory Insufficiency: The Program failed to establish an accident and emergency response policy that included provisions for head injuries.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #1 no longer resides at Bickford as of 06/04/20.
- Tenant #2 no longer resides at Bickford as of 6/25/20.
- Tenant #3 no longer resides at Bickford as of 4/1/21.
- RNC performed a Nursing Assessment, Cognitive Assessment, Service Assessment and a Service Plan update for Tenant #4 on 3/8/21.

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

- Divisional Director of Resident Services provided education on 5/13/21 to the Director and RNC on the Falls with Possible Head Injury Policy.
- The Director, RNC or designee will provide education to new staff members, upon hire, on the Falls with Possible Head Injury Policy.
- Director, RNC or designee will educate all staff members on Falls with Possible Head Injury Policy on 5/17/21-5/18/21. Those staff who are not in attendance shall be provided 1:1 education by Director, RNC or designee.

The program will monitor performance to ensure compliance as follows:

- The Director, RNC or designee will review all Unusual Occurrence documentation to ensure that program staff properly complied with the Falls with Possible Head Injury Policy.
- Director, RNC or designee will provide individual education or counseling for staff members who are not compliant with following appropriate policy guidelines.
- Divisional will audit resident records twice per year during onsite visits to ensure that the Falls with Possible Head Injury Policy is followed.

Date deficiencies corrected by: 05/18/21

A145—481-69.22(3) Evaluation of Tenant

Regulatory Insufficiency: Program failed to complete evaluations as needed with significant change.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #1 no longer resides at Bickford as of 06/04/20.
- Tenant #2 no longer resides at Bickford as of 6/25/20.
- Tenant #3 no longer resides at Bickford as of 4/1/21.
- RN performed a Nursing Assessment, Cognitive Assessment, Service Assessment and a Service Plan update for Tenant #4 on 3/8/21

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

- Divisional Director of Resident Service provided RNC re-education to the RNC on Assessment Policy, Nurse Review Policy, Service Planning and Documentation Policy on 5/13/21.
- RNC will review Task Sheets, Unusual Occurrence Reports, Communication Book and observe residents for significant changes and complete evaluations as needed.
- Divisional Director of Resident Services or designee will conduct weekly calls with the RNC to review resident Unusual Occurrence reports and potential need for significant change evaluations.

The program will monitor performance to ensure compliance as follows:

- Divisional will audit resident records at least twice per year during onsite visits and as needed to ensure that residents who have significant changes are evaluated.

Date deficiencies corrected by: 05/18/21

A 380- 481-69.26(3) Service Plans:

Regulatory Insufficiency: The program failed to update service plans as needed with significant change.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #1 no longer resides at Bickford as of 06/04/20.
- Tenant #2 no longer resides at Bickford as of 6/25/20.
- Tenant #3 no longer resides at Bickford as of 4/1/21.
- RNC performed a Nursing Assessment, Cognitive Assessment, Service Assessment and a Service Plan update for Tenant #4 on 3/8/21.

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

- Divisional Director of Resident Services provided education to the Director and RNC on Service Plan Policy on 05/13/21.
- RNC will review Task Sheets, Unusual Occurrence Reports, Communication Book and observe residents for significant changes that trigger the initiation of new evaluations and Service Plan updates.

The program will monitor performance to ensure compliance as follows:

- Divisional will audit resident records at least twice per year during onsite visits to determine Service Plans were updated as needed with significant change.

Date deficiencies corrected by: 05/18/21