IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
51587-C
51025-I

April 6, 2015

Ms. Jenniffer Westfall, Director
Bickford Cottage Ames
2418 Kent Avenue
Ames, IA 50010

RE: Final Recertification and Complaint/Incident Investigation Report, Bickford Cottage Ames, Ames, Iowa

Dear Ms. Westfall:

Enclosed is the **Final Recertification and Complaint/Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following an investigation by DIA on **March 24, 25, 26 and 30, 2015.** No regulatory insufficiencies were identified related to the incident #51025-I.

On 11-11-14 the Program reported to the Department that a tenant fell after tripping over a walker when getting up from the table. An incident report was completed and the Department was notified appropriately. Initial examination of the tenant following the fall did not indicate an injury was present. Per the physician's order, the tenant was observed overnight. The progress notes documented follow-up by the RN at 6:00 a.m. the following morning and found to be in pain and refusing to bear weight. The family was notified. The son-in-law who is a physician was onsite. It was documented the son-in-law did not find conclusive evidence of injury, but the tenant was sent to the hospital where the tenant was diagnosed with a hip fracture.

At the time of the incident, the service plan identified the tenant walked independently with a walker, and walked independently around the building during the day. The tenant returned to the Program on 11-24-14. Evaluations and service plan were completed at that time.

The Report notes Regulatory Insufficiencies cited during the recertification and investigation of #51587-C in the area(s) of: Program policies and procedures, Medications, Staffing, Record Checks, Evaluation of Tenant, Criteria for Admission/Retention of Tenants, Service Plans and Nurse Review.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

Enclosed is the Assisted Living Program Certificate **S0024** with effective dates of **March 5, 2015** through **March 4, 2017**.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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
	S0024	A BUILDING: _____ B WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 24 Number of tenants with cognitive disorder: 9 Total Population of Program at time of on-site: 33 TOTAL census of Assisted Living Program: 33 No regulatory insufficiencies were cited during the investigation of Incident# 51025-I. The following regulatory insufficiencies were cited during the recertification and investigation of Complaint # 51587-C.	A 000		
A 004	481-67.2(1)a Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. 67.2(1) The program ' s policies and procedures on incident reports, at a minimum, shall include the following: a. The program shall have available incident report forms for use by program staff.	A 004		

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A 004	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and a review of policies, the Program's policies were not followed. A review of the eye drop administration policy revealed gloves were to be used. 1. On 3-30-15 at 8:23 a.m. Staff B was observed administering Combigen eye drops to Tenant #6. Staff B did not apply gloves. 2. On 3-30-15 at 8:31 a.m. Staff B was observed administering Dorzolamide eye drops to Tenant #6. Staff B did not apply gloves. Hands were not washed after the medication was administered. A review of the handwashing policy revealed staff was to wash hands between contact with different residents, before and after performing treatments or procedures, and after situations which spread of infection is likely to occur especially those involving contact with mucous membranes or body fluids. 3. After administering eye drops with ungloved hands to Tenant #6 at 8:31 a.m., Staff B administered medications to Tenant #1 without washing hands first. 4. At 8:49 a.m. Staff B administered medications to Tenant #5 in Tenant #5's apartment. Staff B left the apartment without washing hands. After leaving Tenant #5's apartment, Staff B went to Tenant #7's apartment to administer medications.	A 004		

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A 004	Continued From page 2 Staff B did not wash hands upon entering the apartment or before leaving the apartment.	A 004		
A 036	481-67.5(6)a Medications 481-67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following: 67.5(6) When medications are administered traditionally by the program: a. The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67.9(4) or a physician assistant (PA) in accordance with 645-Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA). This REQUIREMENT is not met as evidenced by: Based on observation, medication orders, and interview, medications were not administered correctly. 1. On 3-30-15 at 8:10 a.m. Staff B was observed administering sliding-scale insulin to Tenant #3. Staff B did not cleanse the skin prior to the insertion of the needle into the abdomen. Staff B stated no skin preparation was necessary. On 3-30-15 at 10:15 a.m. the RN was interviewed and stated an alcohol swab should be used on the skin prior to the administration of	A 036		

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A 036	Continued From page 3 insulin. 2. On 3-30-15 at 8:17 a.m., Staff B was observed administering medications . The Program utilized an electronic medication administration record (MAR). Staff B was observed applying Triamcinilone cream to Tenant #4's legs. Staff B did not check the MAR prior to the application of the cream. Staff B went to document the application of the cream when completed and was unable to locate the order for the cream. A review of the physician's orders for Tenant #4 revealed the Triamcinilone cream was ordered to be used the first 14 days of each month. According to the orders the cream was not to be administered on the 30th of the month, the date of the observation. 3. On 3-30-15 at 8:49 a.m. Staff B was observed administering medications to Tenant #5. Tenant #5 requested a pill be split in half for easier swallowing. Staff B was observed using bare hands to break the pill in half. On 3-30-13 at 10:15 a.m. the RN was interviewed and stated pills should not be touched with bare hands.	A 036		
A 064	481-67.9(4)g Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: g: The program shall have in place a system by which certified or noncertified staff	A 064		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 064	Continued From page 4 communicate in writing occurrences that differ from the tenant ' s normal health, functional and cognitive status. The program ' s registered nurse or designee shall train certified and noncertified staff on reporting to the program ' s registered nurse or designee and documenting occurrences that differ from the tenant ' s normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request. This REQUIREMENT is not met as evidenced by: Based on interview and the inability of the Program to provide documentation as requested, the Program failed to have in place a system for staff members to communicate tenant occurrences in writing and failed to keep written staff communication for three years. 1. The monitor was onsite to complete an incident and complaint investigation. The Program was asked to provide the written staff communication detailing occurrences that differed from tenants' normal health, functional and cognitive status, and going back several months related to the investigations. The Registered Nurse (RN) was interviewed on 3-24-15 at 11:35 a.m. and stated the staff wrote notes and stuck them under her office door. The RN did not keep the notes. Sometimes the staff called the RN on the phone, but staff did not follow up with written communication. The RN stated she wrote in the chart when there was something significant. The RN stated she did not write if it was "nothing." The RN stated there was	A 064		

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A 064	Continued From page 5 a staff communication book that was kept "for a day or so." The Administrator was interviewed on 3-24-15 at 11:40 a.m. and stated staff would document in the nurse's notes if there was an incident or on an incident report. The Program was unable to provide the written communication upon request.	A 064		
A 121	481-67.19(3)c Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3)c If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person ' s employment in the program. This REQUIREMENT is not met as evidenced by: Based on background check review and review of email communication, the Program failed to request an evaluation from the department of human services. 1. Background checks for Staff F were completed on 10-9-14 using SING. There were no records of child abuse or dependent adult abuse found. The criminal history check revealed further	A 121		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 121	Continued From page 6 research was required. The Department of Criminal Investigation returned a criminal history record to the Program on 10-20-14. The criminal history record indicated it was a non conviction with deferred judgement. The Program received an email from the corporate office in Olathe, Kansas that further investigation was not required because it was a non-conviction. In a publication "Record Checks-Frequently Asked Questions" dated 8-2014 available online at the Department of Inspections and Appeals website, a deferred judgement is considered a conviction for the purposes of the records check. Iowa Administrative Code 481-67.19(8) allows for transfer from one certified program to another as an exception to the record check evaluation. Staff F had provided to the Program, Department of Human Services clearance for Staff F to participate in nursing assistant training at a community college. Staff F went from nursing assistant training to employment in an assisted living program. Staff F did not transfer from one certified program to another. Staff F was hired on 10-30-14 without completion of a Department of Human Services evaluation after the Department of Criminal Investigation evaluation revealed a history.	A 121		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant ' s functional,	A 037		

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A 037	Continued From page 7 cognitive and health status within 30 days of occupancy. A program shall also 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 or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, evaluations of function, cognition, and health were not completed with changes of condition to determine continued eligibility for the program and to determine any changes to services needed. Seven records were reviewed. 1. Tenant #8, an 88 year-old, was admitted on 12-31-12 and had diagnoses of: atrial fibrillation, dementia, history of bilateral knee replacements, and Parkinson's disease. On 2-16-15 Tenant #8 was staged at three on the Global Deterioration Scale (GDS) which indicated mild cognitive decline. According to progress notes dated 2-16-15, Parkinson's disease continued to change Tenant #8's strength. Tenant #8 required assist of one and ambulated with a walker. Tenant #8 was exhibiting weight loss. Tenant #8 preferred staying in the apartment and napping rather than attending activities. Evaluations of function, cognition, and health were completed. A lift chair	A 037		

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A 037	Continued From page 8 was put in place following falls from getting in and out of a recliner. The service (functional) evaluation dated 2-16-15 and completed by the RN revealed Tenant #8 needed reminders for meal times and documented Tenant #8 sometimes had difficulty sitting down at the table. Staff was to assist as needed. The service evaluation also documented Tenant #8 had increased one-sided weakness for which Tenant #8 required assistance in dressing. The service evaluation documented Tenant #8 could ambulate with a walker to the bathroom, with assist of one to two for escort. A gait belt could be used. Tenant #8 could hold onto the grab bar by the toilet and pivot to sit with staff assist. The service evaluation documented Tenant #8 used a walker for ambulation, and staff provided assistance with gait belt and hands-on assist for safety. The evaluation documented Tenant #8 was getting weaker. A wheelchair was used when Tenant #8 was unable to ambulate safely. The service evaluation documented the family found it increasingly difficult to take Tenant #8 out of the building for doctor visits. It was documented Tenant #8 was disoriented and needed reminders of the daily routine. The nurse (health) evaluation dated 2-16-15 and completed by the RN documented Tenant #8 complained of numbness, possibly attributed to the Parkinson's disease. The left shoulder and elbow were stiff and the hand shook at times. It was documented Tenant #8 was often unable to successfully use the left arm. It was documented Tenant #8 had moderate limited range of motion of the lower extremities, and that a Parkinson's gait was becoming more apparent. It was documented Tenant #8 had poor posture, poor coordination, and poor balance.	A 037		

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A 037	Continued From page 9 Incident reports documented the following nine events for Tenant #8: 2-20-15 at 7:00 a.m. fall while attempting to sit on shower chair, skin tear left elbow. As needed Ativan had been given twice during the night for restlessness. 2-20-15 at 6:00 p.m. raised electric chair and slid to floor. Tenant #8 reminded to call staff for assist. 2-23-15 at 1:15 a.m. fell attempting to get out of bed, skin tear to right elbow. Staff to bring urinal to bed 2-23-15 at 3:00 a.m. attempting to use urinal, caught in walker with backside up in air as the walker was flipped and holding legs up. Removed walker from bedside to avoid repeat incident. Progress notes dated 2-23-15 and timed 9:00 a.m. documented Tenant #8 was restless and "as needed" Ativan gave temporary rest. A nighttime sleep aid was not recommended by the physician. The RN documented the nurse practitioner would be consulted for suggestions. 2-23-15 at 7:45 p.m. got up on own to use restroom, lost balance, and fell. 3-1-15 at 7:00 p.m. fell while walking back from bathroom. Had left elbow and back pain. Notification to the physician documented Tenant #8 later stated the head was hit during the fall. Progress notes dated 3-3-15 and timed at 12:05 p.m. documented Ativan (for anxiety) and Lexapro (antidepressant) were to be given daily 3-6-15 at 2:15 p.m. walking to the bathroom with	A 037		

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A 037	Continued From page 10 two staff, Tenant #8's legs did not hold, Tenant #8 was lowered to the floor. Documentation on the incident report completed by the RN indicated the family was consulted about possible interventions of private duty caregiver, pillows for comfort in bed, shower chair on rollers, and a bedside commode. The family was considering the interventions. 3-7-15 at 2:44 a.m. found on floor with head on table. Bleeding from right side of head. 911 called. Documentation from the hospital dated 3-7-15 revealed Tenant #8 had scans of the neck, head, and pelvis, and X-rays of the chest, arm, pelvis, and wrist. Staples were used on the head wound. 3-8-15 at 11:15 a.m. Tenant #8 yelling, found on floor, reported falling as legs gave out when leaving bathroom. Tenant #8 struggled to stand up even with two staff. Tenant #8 was resisting. Small cut on wrist. The record lacked documentation of evaluations of function, cognition, and health following multiple falls, and one with a head injury severe enough to require evaluation at a hospital and staples to the head. Evaluations were not completed with significant changes in condition. On 3-24-15 at 1:10 p.m. Staff B stated Tenant #8 had Parkinson's disease and had declined. Staff B stated Tenant #8 routinely required two staff for transfer and was frequently incontinent. On 3-25-15 at 9:41 a.m. Staff C stated Tenant #8 could not stand. Tenant #8 required two persons for transfer 100% of the time, and sometimes took three persons for transfer. Staff C reported Tenant #8 did not walk. Tenant #8 was "stiff" but	A 037		

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A 037	Continued From page 11 tried to move extremities to assist with dressing. On 3-25-15 at 10:19 a.m. Staff D stated Tenant #8 had required the assistance of two persons for transfers for the last one to one and a half months. Staff D stated Tenant #8 thought he/she was assisting by pushing up, but was really pushing down so as to resist transferring. Tenant #8 was described as "dead weight" who did not bear weight on the legs. Tenant #8 was reported to use the wheelchair and did not walk. Staff D reported Tenant #8's arms did not move a lot. The left arm needed to be moved manually by staff as Tenant #8 did not move the left arm. On 3-24-15 at 2:19 p.m. Staff E reported Tenant #8 routinely took two persons for transfer. On 3-25-15 at 8:44 a.m. Staff F reported Tenant #8 got bed baths as it was difficult to get Tenant #8 in and out of the whirlpool bath. Tenant #8 used a wheelchair for mobility, and transferred with the assist of two. Staff F reported it took three persons to dress Tenant #8, two to hold Tenant #8 and one to dress. Tenant #8 required assistance of two to transfer and used a commode and did not use the toilet. Staff F reported Tenant #8 had been a routine two-person transfer 100% of the time for four to six weeks. On 3-25-15 at 4:30 p.m. Staff G was interviewed and stated Tenant #8 had been declining for the last month. Staff G thought it was about the time the anti-anxiety medication was ordered. Staff G reported Tenant #8 thought objects were closer than they actually were, and Tenant #8 would try to sit even though the seat was not close. Tenant #8 was weaker.	A 037		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 037	Continued From page 12 The RN was interviewed on 3-25-15 at 12:40 p.m. and stated she looked at the ability to stand, balance, and pivot to determine the ability to transfer. The RN stated the tenant must be able to balance and could use a walker for that balance. The following observations were made: On 3-24-15 at 2:06 p.m. Tenant #8 was in the common area in a wheelchair. Staff B propelled Tenant #8 in the wheelchair to the apartment. The left arm appeared immobile. Staff E came in to assist. A gait belt was applied. Tenant #8's hands were guided to the walker. The staff grabbed the gait belt. Tenant #8 used the legs very little to lift. The buttocks remained out, and Tenant #8 did not stand upright. The left hand did not grip the walker. The staff members attempted to pivot Tenant #8 to the chair. The walker tipped, but Staff B and E were able to get Tenant #8 into the chair. Staff E stated Tenant #8 did not stand upright often, and did not use the left arm. Staff E stated Tenant #8 was mostly a two person transfer 75 to 90% of the time. On 3-25-15 at 11:35 a.m. in Tenant #8's apartment with Staff C And D. Tenant #8 was in the lift chair and the lift chair was raised to the upright position. A gait belt was applied, and staff counted to three to lift. Tenant #8 pushed backwards and the buttocks was out. Tenant #8 was working against the transfer. Tenant #8 was transferred to the wheelchair that was on the left side, Tenant #8's weaker side. On 3-25-15 at 4:40 p.m. Staff G was observed during the transfer of Tenant #8. Tenant #8 was in the apartment and the lift chair was elevated. Tenant #8 was asked to use the walker to hold onto to stand so that pants could be changed.	A 037		

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
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A 037	Continued From page 13 The left hand did not grip the walker firmly. The left hand was shaking. Tenant #8 was leaning to the left. Tenant #8 raised the buttocks from the chair but was pressing backwards. The pants were removed. Tenant #8 did not reposition the feet upon request of Staff G. Staff G manually repositioned the feet. Once the pants were changed the gait belt was applied. The walker was positioned again in front of the lift chair and the wheelchair was to the left. Tenant #8 was instructed to stand up tall. Tenant #8 raised the buttocks from the raised lift chair but was pushing backwards. Staff G was providing a grip to the gait belt. Tenant #8 was asked to walk forward, but was unable to move the feet. Staff G moved the walker forward and Tenant #8 took tiny steps. Tenant #8 began to lean, but was not moving in the direction of the wheelchair. Staff G moved Tenant #8 to the wheelchair. Staff G was in a crouched position with arms outstretched at the end of the transfer. Staff G confirmed that Tenant #8 did not pivot into the wheelchair. Tenant #8 was asked to lift the feet to put them in the footrests on the wheelchair. Tenant #8 could not put the feet on the footrests and Staff G had to do it manually. Staff G asked Tenant #8 to use the arm to push self in the wheelchair to reposition. Tenant #8 was unable to reposition self in the wheelchair so Staff G came from behind to raise Tenant #8 from the back, using the gait belt. On 3-26-15 at 11:37 a.m. Staff B and C were in Tenant #8's apartment. Tenant #8 was in the lift chair and the lift chair was raised to the upright position. A gait belt was applied. Staff counted to lift. Tenant #8's upper extremities were shaking and Tenant #8 pushed back in the opposite direction according to Staff B and C. Tenant #8 was transferred to the wheelchair positioned to the left of the lift chair. Staff C reported Tenant #8	A 037		

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
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A 037	Continued From page 14 did not use the bathroom but used the commode that was observed to be present in the apartment. Staff C reported Tenant #8 had required two persons for transfer for the last one to one and a half months. On 3-30-15 at 11:32 a.m. Staff C and Staff F were in Tenant #8's apartment. The lift chair was raised and the gait belt was applied. One staff member was under each arm. After counting, Staff C and F raised Tenant #8 and transferred Tenant #8 to the wheelchair positioned to the left of the lift chair. Tenant #8 pushed backwards and kept the buttocks out. Tenant #8 was asked if it always took to people to get Tenant #8 into the chair; Tenant #8 replied "yes." The RN was interviewed on 3-25-15 at 12:40 p.m. and stated she looked at the ability to stand, balance, and pivot to determine the ability to transfer. The RN stated the tenant must be able to balance and could use a walker for that balance. Tenant #8 was observed on several occasions over several days. Tenant #8 did not demonstrate adequate lower body strength to stand or balance and was not able to bear full weight on the legs. Tenant #8 had limited strength in the upper extremities as well as shaking of the upper extremities, and although cognitively able, was not physically able to follow directions to move feet or arms. Tenant #8 resisted transfer by pushing backwards, and kept the buttocks out, and would lean to one side. Tenant #8 required the assistance of two persons for transfer for safety during all observations. Evaluations were completed for Tenant #8 on 2-16-15. The documentation revealed Tenant #8	A 037		

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
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A 037	Continued From page 15 was getting weaker, and was requiring more assistance for transfers. It was documented Tenant #8 had poor posture, poor coordination, and poor balance. After the evaluations, Tenant #8 had nine documented falls, one of which resulted in a head injury requiring staples. Medications for anxiety and depression were prescribed on 3-3-15. Staff interviews revealed Tenant #8 had declined over the last one to one and a half months and was routinely requiring two persons for transfer. The RN did not complete evaluations after 2-16-15 with significant changes of condition to determine continued eligibility for the program and to determine changes to services needed. 2. Tenant #10, an 88 year-old, was admitted on 7-25-14 and had diagnoses of: coronary artery disease, dementia, and hypertension. On 1-16-15 Tenant #10 was staged at four on the GDS which indicated moderate cognitive decline. According to the service (functional) evaluation completed 1-16-15, Tenant #10 ambulated short distances with a walker, a gait belt, and a staff member. The nurse (health) evaluation dated 1-16-15 documented Tenant #10 had poor coordination and poor balance. The service plan dated 1-16-15 documented staff were to follow with a wheelchair when Tenant #10 was ambulating, and assist of one was needed for transfer. A 90-day nurse review dated 1-16-15 documented in the progress notes revealed in early November Tenant #10 was ill, ate very little and stayed in bed. It was documented Tenant #10 was weaker at that point and began to lose weight. Tenant #10 had stopped ambulating and no longer took self to the bathroom. At the time	A 037		

DEPARTMENT OF INSPECTIONS AND APPEALS

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	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

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A 037	Continued From page 16 of the nurse review, Tenant #10 was now ambulating short distances with staff, walker, and gait belt. Tenant #10 had received physical therapy (PT) but was discharged from PT on 1-16-15. Staff B was interviewed on 3-24-15 at 1:10 p.m. and stated Tenant #10 used the grab bar in the bathroom to transfer with the assist of one staff. Staff B reported Tenant #10 talked to the television, and was "very" incontinent through the night. Staff C was interviewed on 3-25-15 at 9:41 a.m. Staff C stated Tenant #10 required the assist of two persons 60-70% of the time. It was routine to use two persons to transfer Tenant #10. Staff D was interviewed on 3-25-15 at 10:19 a.m. and stated Tenant #10 sometimes had good days. On other days, Tenant #10 would scream, was afraid and confused. Staff D reported Tenant #10 was always a two-person transfer in the morning, and required two persons 60% of the time during the rest of the day. Tenant #10 was incontinent and did not always tell staff when the bathroom was needed. Staff E was interviewed on 3-24-15 at 2:19 p.m. and stated Tenant #10 always required the assist of two persons to transfer the first of the day. Staff E used two persons to transfer Tenant #10. Staff F was interviewed on 3-25-15 at 8:44 a.m. and stated Tenant #10 required the assist of two persons for transfer. Staff F stated Tenant #10 has had bad days since January, and has routinely required the assist of two, at least 75 % of the time, for the last four to six weeks.	A 037		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

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A 037	Continued From page 17 The RN was interviewed on 3-25-15 at 12:40 p.m. and stated she looked at the ability to stand, balance, and pivot to determine the ability to transfer. The RN stated the tenant must be able to balance and could use a walker for that balance. On 3-25-15 at 11:42 a.m. Staff C and D entered Tenant #10's apartment. Tenant #10 was sitting in the recliner and leaning to the left side. Tenant #10 leaned forward for the application of a gait belt. Staff gave Tenant #10 instructions to stand up, and sit in the wheelchair. A count of three was given. Tenant #10 began yelling. As Tenant #10 was being transferred, Tenant #10 remained in a sitting position with the buttocks out. There was no obvious weight bearing to the legs and only one foot was on the ground during transfer. The legs twisted as Tenant #10 was transferred from the chair to wheelchair. Staff C and D transferred Tenant #10 from the chair to the wheelchair. Tenant #10 was wheeled into the bathroom of the apartment. With staff direction, Tenant #10 grabbed the bar by the toilet. Staff removed the pants. Tenant #10 was attempting to sit while the pants were removed. Tenant #10 was not over the toilet at the time of sitting. Both staff pivoted Tenant #10 to the toilet. Staff C reported a foot rest was used when Tenant #10 was seated on the toilet because Tenant #10 had a fear of falling. PT instructed staff to use the foot rest. At 11:51 a.m., Staff C and D lifted Tenant #10 from the toilet. Tenant #10 remained in a seated position. Staff C and D used the gait belt for transfer from the toilet to the wheelchair. Both	A 037		

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
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A 037	Continued From page 18 stated Tenant #10 would have fallen if they had let go of the gait belt. On 3-25-15 at 12:40 p.m. the RN was notified by the monitor that Tenant #10 had been observed for transfers and took two persons for transfers. The RN stated the staff had not notified her that Tenant #10 required the assistance of two persons for transfer. On 3-25-15 at 2:45 p.m. Staff B was observed with Tenant #10. Tenant #10 was in the wheelchair and was taken to the bathroom. A gait belt was not used despite the direction on the service plan to do so. Staff B instructed Tenant #10 to hang onto the grab bar. Staff B physically directed Tenant #10's hands to the grab bar. Tenant #10 was instructed to put feet on the floor and stand. Tenant #10 stated "I can't." Tenant #10 was given the count of three to stand, and the bar was grabbed. Staff B used the hands at the hips and assisted Tenant #10 to stand. Tenant #10 was upright but fell backwards and was unsteady on the feet. Tenant #10 was pivoted to the toilet. Tenant #10 was sitting on the toilet. Tenant #10 twisted at the waist to grab the bar located next to the toilet after instructed by Staff B. The feet were forward, but the upper body was twisted, and the buttocks were out as in a seated position. Tenant #10 did not stand straight. As the incontinence product was pulled up, Tenant #10 sat down. Tenant #10 was asked to stand up. Again the upper body was twisted to grab the bar. Staff B used the pants to lift Tenant #10. Tenant #10 remained in a seated position and did not stand upright. Tenant #10 was pivoted to the wheelchair. Tenant #10 was asked by Staff B to push self back in the wheelchair. Tenant #10 did	A 037		

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
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A 037	Continued From page 19 not have the upper body strength to push self back in the wheelchair without assistance. Staff B reported the wheelchair was used for mobility. On 3-26-15 at 9:07 a.m. Staff C and D were observed with Tenant #10 who was in a wheelchair. The gait belt was applied by Staff D. Tenant #10 was taken into the bathroom. Tenant #10 was instructed to grab the bar. The hands went to the rail, but the buttocks were kept out as in a seated position. Staff C and D were holding onto Tenant #10 with the gait belt. Staff C stated Tenant #10 would fall if not holding onto the gait belt. Tenant #10 sat down. A second attempt was made. Tenant #10 again kept the buttocks out while using the grab bar. Both staff were hanging onto the gait belt. Both staff removed the pants and Tenant #10 was pivoted to the toilet. Staff C and D stated it took two persons to transfer Tenant #10 most of the time. Tenant #10 had PT, but has declined since that time. It was reported PT services ended about two months earlier. Staff C stated she had gotten Tenant #10 up one time since Christmas using only one person for assistance. At 9:17 a.m. Tenant #10 stated "where are we?" Tenant #10 was prompted to stand and to use the grab bar. Tenant #10 kept the buttocks out but was pushing backwards. Staff C stated Tenant #10 would fall if she let go. Tenant #10 attempted to sit when the wheelchair was not behind the legs. Tenant #10 was hollering during the transfer. At 9:20 a.m. Tenant #10 was transferred from the wheelchair to the chair with assistance from Staff C and D. Tenant #10 was pivoted with the assist	A 037		

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A 037	Continued From page 20 of the two staff. It was reported Tenant #10 only did "a little" weight bearing on the legs. Tenant #10 was too afraid of falling to assist according to the staff. On 3-30-15 at 10:49 a.m. Staff B and C were observed with Tenant #10. Tenant #10 was in the wheelchair and transferred from the dining room to the bathroom in the apartment. A gait belt was not applied. Tenant #10 was cued to grab the bar next to the toilet. Hands were guided to the bar. Tenant #10 stood up but remained in a seated position. Tenant #10 began hollering and sitting. Staff B pivoted Tenant #10 to the toilet. The incontinence products had not yet been removed. Staff B reported Tenant #10 began to drop and she pivoted Tenant #10 to the toilet. The incontinence products were removed while Tenant #10 was seated on the toilet. At 10:54 a.m. Tenant #10 was hollering and stated "I can't sit here!" Tenant #10 leaned forward and grabbed the bar. Tenant #10 was unable to pull self up from the toilet. Tenant #10 remained in a seated position while being supported by staff. Staff B pulled up pants. Tenant #10 was attempting to sit while the pants were being pulled up. Tenant #10 was pivoted to the wheelchair. On 3-30-15 at 10:15 the RN was interviewed and asked if she had been in to evaluate Tenant #10 since the monitor reported observations of two-person transfers on 3-25-15. The RN stated she had spoken with Staff B who had transferred Tenant #10 with an assist of one afterwards. The RN stated Tenant #10 had not been evaluated. Tenant #10 was observed on several occasions over several days. Tenant #10 did not	A 037		

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
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A 037	Continued From page 21 demonstrate adequate lower body strength to stand or balance and was not able to bear full weight on the legs. Tenant #10 had limited strength in the upper extremities. Tenant #10 was not cognitively able to follow directions as evidenced by continually remaining in a seated position and attempting to sit with no seat underneath. Tenant #10 resisted transfer by hollering "I can't!" Tenant #10 required the assistance of two persons for transfer for safety during all observations. Evaluations for Tenant #10 were completed on 1-16-15 immediately following the completion of PT and revealed Tenant #10 had poor coordination and poor balance. The service plan dated 1-16-15 documented staff were to follow with a wheelchair when Tenant #10 was ambulating, and assist of one was needed for transfer. The RN was informed on 3-25-15 that Tenant #10 had been observed to require the assistance of two for transfer. The RN stated Tenant #10 was not evaluated but relied upon information from an unlicensed staff member to determine Tenant #10's ability to transfer safely. Tenant #10 was partially able to bear weight and was not able to demonstrate upper body strength. Tenant #10 resisted transfers, was calling out, and kept the buttocks out. Tenant #10 did not follow instructions to stand, and sat at will. Tenant #10 was observed to require assistance of two persons during observed transfers. Tenant #10 required routine two-person assistance for transfer for safety. Tenant #10 had declined since the evaluations completed on 1-16-15. Tenant #10 was not observed to ambulate and was pushed in a wheelchair for mobility. Staff	A 037		

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
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A 037	Continued From page 22 interviews revealed Tenant #8 had declined over the last one to one and a half months and was routinely requiring two persons for transfer. The RN did not complete evaluations after 1-16-15 with significant changes of condition to determine continued eligibility for the program and to determine changes to services needed. 3. Tenant #11, an 87 year-old, was admitted on 8-18-14 and had diagnoses of: chronic inflammatory demyelinating polyneuropathy, benign prostatic hypertrophy, and atrial fibrillation. On 12-12-14 Tenant #11 was staged at one on the GDS which indicated no cognitive decline. Progress notes dated 3-2-15 documented Tenant #11 was sent to the hospital for a decline in condition and did not return to the Program. On 12-4-14, Tenant #11 was admitted to the hospital for acute pharyngitis. According to the documentation from the hospital, Tenant #11 had several days of sore throat and increasing difficulty swallowing with a history of vomiting. Tenant #11 arrived at the hospital via ambulance. The hospital documentation documented Tenant #11 had a sore throat secondary to severe pharyngitis with impending airway obstruction. Tenant #11 was admitted to the intensive care unit. Tenant #11 also was diagnosed with pneumonia. A review of the clinical record revealed no evaluations completed after 9-10-14 until return from hospitalization on 12-12-14. There were no progress notes after 11-21-14 until return from hospitalization on 12-12-14. The clinical record lacked any documentation of Tenant #11's condition that led to hospitalization. Tenant #11 experienced a change of condition	A 037		

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
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BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 037	Continued From page 23 that warranted transport to the hospital via ambulance. Tenant #11 was admitted with severe pharyngitis with impending airway obstruction. Evaluations of Tenant #11 were not completed with a changing condition. Progress notes dated 12-18-14 documented Tenant #11 went to the hospital by ambulance and returned the same day with an order for a hospital bed and an antibiotic for 10 days. A progress note from the physician dated 12-22-14 documented Tenant #11 was seen in the emergency room on 12-18-14 and diagnosed with acute bronchitis. The physician documented Tenant #11 struggled chronically with breathing when lying flat on the back. A hospital bed was ordered to keep the head of the bed elevated secondary to gastroesophageal reflux disease. The physician documented Tenant #11 did not move independently and required transfers. Tenant #11 was noted to be at risk for skin breakdown. The physician documented Tenant #11 required a hospital bed as a medical necessity to assist Tenant #11 with breathing, swallowing, and ridding self of respiratory secretions. An air mattress was recommended to prevent skin breakdown. The RN noted the documentation on 1-13-15. A speech therapist documented on 1-15-15 it was recommended pills be placed in pudding or applesauce. The therapist would see Tenant #11 for difficulty swallowing. Speech therapy notes dated 1-20-15 documented Tenant #11 demonstrated overt signs and symptoms of aspiration with meals. The therapist documented Tenant #11 had not received a handled cup at meals and medications were not	A 037		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

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A 037	Continued From page 24 given in applesauce as recommended. Therapy notes dated 1-27-15 documented the therapist continued to be concerned about aspiration. Evaluations were not completed with a changes of condition, respiratory and swallowing difficulties. 4. Tenant #12, a 90 year-old, was admitted on 10-9-10 and had diagnoses of: gastroesophageal reflux disease, diabetes, hypertension, osteoarthritis, hypertensive encephalopathy, and dementia. On 12-4-14 Tenant #12 was staged at three on the GDS which indicated mild cognitive decline. The service (functional) evaluation dated 12-4-14 documented Tenant #12 required escorts to and from activities and meals. The evaluation revealed a gait belt was to be used for all transfers and a slide board was available as needed. The nurse (health) evaluation of 12-4-14 documented Tenant #12 had severely limited range of motion to both upper and lower extremities. Tenant #12 had poor posture, poor coordination, and poor balance. Tenant #12 was unable to bear weight. Progress notes dated 11-4-14 timed 9:30 a.m. documented Tenant #12 was on the toilet when Tenant #12 slumped and the head rolled, making "gutteral" noises. Notes documented Tenant #12 had experienced similar episodes several times, usually when on the toilet. The progress notes dated 12-4-14 documented these episodes resembled a Vagal response. Progress notes of 12-4-14 documented Tenant	A 037		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 037	Continued From page 25 #12 had a steady weight loss over the previous months and hospice was being considered. Progress notes dated 12-16-14 and timed 2:17 p.m. documented Tenant #12 would be receiving "pre-hospice" care from a nurse practitioner. Progress notes dated 12-22-14 and 1-5 and 1-12-15 documented Tenant #12 slid out of a lift chair. Progress notes dated 1-17-15 and timed 4:55 a.m. documented Tenant #12 had expired. In an interview with the RN at exit, she stated Tenant #12 had declined just one or two days prior to death. The RN provided a delegation form for end of life care and stated she had prepared the information for staff use. The delegation form instructed every two hour checks for mouth care, perineal care, and repositioning. Staff B was interviewed on 3-24-15 at 1:10 p.m. and stated Tenant #12 always took two to transfer for "quite a long time, several weeks." Tenant #12 was incontinent and was usually wet. Tenant #12 was bedbound the last week of life. Staff C was interviewed on 3-25-15 at 9:41 a.m. and stated Tenant #12 was a two-person assist since last fall. Staff D was interviewed on 3-25-15 at 10:19 a.m. and stated Tenant #12 started sleeping all the time and was bedbound the last month of life. Staff E was interviewed on 3-24-15 at 2:19 p.m. and stated Tenant #12 required two persons for transfer for weeks or months.	A 037		

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 037	Continued From page 26 Staff F was interviewed on 3-25-15 at 8:44 a.m. and stated Tenant #12 required two persons for transfer 100% of the time the last month of life. Tenant #12 was incontinent and sometimes needed assistance to eat. Evaluations of function, cognition, and health were not completed after 12-4-14 to determine continued eligibility for the Program and to determine any changes to services needed.	A 037		
A 039	481-69.23(1)b Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and 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: Complaint #51587-C alleged several tenants exceeded criteria for retention due to unmanageable incontinence and the need for the assistance of two for transfer. Seven tenants were reviewed. Based on record review, interview, and observations, two tenants required routine two-person assist with transfer and exceeded criteria for retention. 1. Tenant #8, an 88 year-old, was admitted on 12-31-12 and had diagnoses of: atrial fibrillation, dementia, history of bilateral knee replacements, and Parkinson's disease. On 2-16-15 Tenant #8 was staged at three on the Global Deterioration	A 039		

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
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A 039	Continued From page 27 Scale (GDS) which indicated mild cognitive decline. According to progress notes dated 2-16-15, Parkinson's disease continued to change Tenant #8's strength. Tenant #8 required assist of one and ambulated with a walker. Tenant #8 was exhibiting weight loss. Tenant #8 preferred staying in the apartment and napping rather than attending activities. Evaluations of function, cognition, and health were completed. A lift chair was put in place following falls from getting in and out of a recliner. The service (functional) evaluation dated 2-16-15 and completed by the RN revealed Tenant #8 needed reminders for meal times and documented Tenant #8 sometimes had difficulty sitting down at the table. Staff was to assist as needed. The service evaluation also documented Tenant #8 had increased one-sided weakness for which Tenant #8 required assistance in dressing. The service evaluation documented Tenant #8 could ambulate with a walker to the bathroom, with assist of one to two for escort. A gait belt could be used. Tenant #8 could hold onto the grab bar by the toilet and pivot to sit with staff assist. The service evaluation documented Tenant #8 used a walker for ambulation, and staff provided assistance with gait belt and hands-on assist for safety. The evaluation documented Tenant #8 was getting weaker. A wheelchair was used when Tenant #8 was unable to ambulate safely. The service evaluation documented the family found it increasingly difficult to take Tenant #8 out of the building for doctor visits. It was documented Tenant #8 was disoriented and needed reminders of the daily routine. The nurse (health) evaluation dated 2-16-15 and	A 039		

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
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A 039	Continued From page 28 completed by the RN documented Tenant #8 complained of numbness, possibly attributed to the Parkinson's disease. The left shoulder and elbow were stiff and the hand shook at times. It was documented Tenant #8 was often unable to successfully use the left arm. It was documented Tenant #8 had moderate limited range of motion of the lower extremities, and that a Parkinson's gait was becoming more apparent. It was documented Tenant #8 had poor posture, poor coordination, and poor balance. Incident reports documented the following nine events for Tenant #8: 2-20-15 at 7:00 a.m. fall while attempting to sit on shower chair, skin tear left elbow. As needed Ativan had been given twice during the night for restlessness. 2-20-15 at 6:00 p.m. raised electric chair and slid to floor. Tenant #8 reminded to call staff for assist. 2-23-15 at 1:15 a.m. fell attempting to get out of bed, skin tear to right elbow. Staff to bring urinal to bed 2-23-15 at 3:00 a.m. attempting to use urinal, caught in walker with backside up in air as the walker was flipped and holding legs up. Removed walker from bedside to avoid repeat incident. Progress notes dated 2-23-15 and timed 9:00 a.m. documented Tenant #8 was restless and "as needed" Ativan gave temporary rest. A nighttime sleep aid was not recommended by the physician. The RN documented the nurse practitioner would be consulted for suggestions. 2-23-15 at 7:45 p.m. got up on own to use	A 039		

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
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BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 039	Continued From page 29 restroom, lost balance, and fell. 3-1-15 at 7:00 p.m. fell while walking back from bathroom. Had left elbow and back pain. Notification to the physician documented Tenant #8 later stated the head was hit during the fall. Progress notes dated 3-3-15 and timed at 12:05 p.m. documented Ativan (for anxiety) and Lexapro (antidepressant) were to be given daily 3-6-15 at 2:15 p.m. walking to the bathroom with two staff, Tenant #8's legs did not hold, Tenant #8 was lowered to the floor. Documentation on the incident report completed by the RN indicated the family was consulted about possible interventions of private duty caregiver, pillows for comfort in bed, shower chair on rollers, and a bedside commode. The family was considering the interventions. 3-7-15 at 2:44 a.m. found on floor with head on table. Bleeding from right side of head. 911 called. Documentation from the hospital dated 3-7-15 revealed Tenant #8 had scans of the neck, head, and pelvis, and X-rays of the chest, arm, pelvis, and wrist. Staples were used on the head wound. 3-8-15 at 11:15 a.m. Tenant #8 yelling, found on floor, reported falling as legs gave out when leaving bathroom. Tenant #8 struggled to stand up even with two staff. Tenant #8 was resisting. Small cut on wrist. The record lacked documentation of evaluations of function, cognition, and health following multiple falls, and one with a head injury severe enough to require evaluation at a hospital and staples to the head. Evaluations were not completed with significant changes in condition.	A 039		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 039	Continued From page 30 The service plan current at the time of the onsite visit was dated 2-16-15 and had not been updated following multiple falls, one of which included a head injury. On 3-24-15 at 1:10 p.m. Staff B stated Tenant #8 had Parkinson's disease and had declined. Staff B stated Tenant #8 routinely required two staff for transfer and was frequently incontinent. On 3-25-15 at 9:41 a.m. Staff C stated Tenant #8 could not stand. Tenant #8 required two persons for transfer 100% of the time, and sometimes took three persons for transfer. Staff C reported Tenant #8 did not walk. Tenant #8 was "stiff" but tried to move extremities to assist with dressing. On 3-25-15 at 10:19 a.m. Staff D stated Tenant #8 had required the assistance of two persons for transfers for the last one to one and a half months. Staff D stated Tenant #8 thought he/she was assisting by pushing up, but was really pushing down so as to resist transferring. Tenant #8 was described as "dead weight" who did not bear weight on the legs. Tenant #8 was reported to use the wheelchair and did not walk. Staff D reported Tenant #8's arms did not move a lot. The left arm needed to be moved manually by staff as Tenant #8 did not move the left arm. On 3-24-15 at 2:19 p.m. Staff E reported Tenant #8 routinely took two persons for transfer. On 3-25-15 at 8:44 a.m. Staff F reported Tenant #8 got bed baths as it was difficult to get Tenant #8 in and out of the whirlpool bath. Tenant #8 used a wheelchair for mobility, and transferred with the assist of two. Staff F reported it took three persons to dress Tenant #8, two to hold	A 039		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 039	Continued From page 31 Tenant #8 and one to dress. Tenant #8 required assistance of two to transfer and used a commode and did not use the toilet. Staff F reported Tenant #8 had been a routine two-person transfer 100% of the time for four to six weeks. On 3-25-15 at 4:30 p.m. Staff G was interviewed and stated Tenant #8 had been declining for the last month. Staff G thought it was about the time the anti-anxiety medication was ordered. Staff G reported Tenant #8 thought objects were closer than they actually were, and Tenant #8 would try to sit even though the seat was not close. Tenant #8 was weaker. The RN was interviewed on 3-25-15 at 12:40 p.m. and stated she looked at the ability to stand, balance, and pivot to determine the ability to transfer. The RN stated the tenant must be able to balance and could use a walker for that balance. The following observations were made: On 3-24-15 at 2:06 p.m. Tenant #8 was in the common area in a wheelchair. Staff B propelled Tenant #8 in the wheelchair to the apartment. The left arm appeared immobile. Staff E came in to assist. A gait belt was applied. Tenant #8's hands were guided to walker. The staff grabbed the gait belt. Tenant #8 used the legs very little to lift. The buttocks remained out, and Tenant #8 did not stand upright. The left hand did not grip the walker. The staff members attempted to pivot Tenant #8 to the chair. The walker tipped, but Staff B and E were able to get Tenant #8 into the chair. Staff E stated Tenant #8 did not stand upright often, and did not use the left arm. Staff E stated Tenant #8 was mostly a two person transfer 75 to 90% of the time.	A 039		

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
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A 039	Continued From page 32 On 3-25-15 at 11:35 a.m. in Tenant #8's apartment with Staff C And D. Tenant #8 was in the lift chair and the lift chair was raised to the upright position. A gait belt was applied, and staff counted to three to lift. Tenant #8 pushed backwards and the buttocks was out. Tenant #8 was working against the transfer. Tenant #8 was transferred to the wheelchair that was on the left side, Tenant #8's weaker side. On 3-25-15 at 4:40 p.m. Staff G was observed during the transfer of Tenant #8. Tenant #8 was in the apartment and the lift chair was elevated. Tenant #8 was asked to use the walker to hold onto to stand so that pants could be changed. The left hand did not grip the walker firmly. The left hand was shaking. Tenant #8 was leaning to the left. Tenant #8 raised the buttocks from the chair but was pressing backwards. The pants were removed. Tenant #8 did not reposition the feet upon request of Staff G. Staff G manually repositioned the feet. Once the pants were changed the gait belt was applied. The walker was positioned again in front of the lift chair and the wheelchair was to the left. Tenant #8 was instructed to stand up tall. Tenant #8 raised the buttocks from the raised lift chair but is pushing backwards. Staff G was providing a grip to the gait belt. Tenant #8 was asked to walk forward, but was unable to move the feet. Staff G moved the walker forward and Tenant #8 took tiny steps. Tenant #8 began to lean, but was not moving in the direction of the wheelchair. Staff G moved Tenant #8 to the wheelchair. Staff G was in a crouched position with arms outstretched at the end of the transfer. Staff G confirmed that Tenant #8 did not pivot into the wheelchair. Tenant #8 was asked to lift the feet to put them in the footrests on the wheelchair. Tenant #8 could not	A 039		

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
	S0024	A. BUILDING. _____ B. WING _____	C 03/30/2015

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A 039	Continued From page 33 put the feet on the footrests and Staff G had to do it manually. Staff G asked Tenant #8 to use the arm to push self in the wheelchair to reposition. Tenant #8 was unable to reposition self in the wheelchair so Staff G came from behind to raise Tenant #8 from the back, using the gait belt. On 3-26-15 at 11:37 a.m. Staff B and C were in Tenant #8's apartment. Tenant #8 was in the lift chair and the lift chair was raised to the upright position. A gait belt was applied. Staff counted to lift. Tenant #8's upper extremities were shaking and Tenant #8 pushed back in the opposite direction according to Staff B and C. Tenant #8 was transferred to the wheelchair positioned to the left of the lift chair. Staff C reported Tenant #8 did not use the bathroom but used the commode that was observed to be present in the apartment. Staff C reported Tenant #8 had required two persons for transfer for the last one to one and a half months. On 3-30-15 at 11:32 a.m. Staff C and Staff F were in Tenant #8's apartment. The lift chair was raised and the gait belt was applied. One staff member was under each arm. After counting, Staff C and F raised Tenant #8 and transferred Tenant #8 to the wheelchair positioned to the left of the lift chair. Tenant #8 pushed backwards and kept the buttocks out. Tenant #8 was asked if it always took to people to get Tenant #8 into the chair; Tenant #8 replied "yes." The RN was interviewed on 3-25-15 at 12:40 p.m. and stated she looked at the ability to stand, balance, and pivot to determine the ability to transfer. The RN stated the tenant must be able to balance and could use a walker for that balance.	A 039		

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
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BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 039	Continued From page 34 Tenant #8 was observed on several occasions over several days. Tenant #8 did not demonstrate adequate lower body strength to stand or balance and was not able to bear full weight on the legs. Tenant #8 had limited strength in the upper extremities as well as shaking of the upper extremities, and although cognitively able, was not physically able to follow directions to move feet or arms. Tenant #8 resisted transfer by pushing backwards, and kept the buttocks out, and would lean to one side. Tenant #8 required the assistance of two persons for transfer for safety during all observations. Evaluations were completed for Tenant #8 on 2-16-15. The documentation revealed Tenant #8 was getting weaker, and was requiring more assistance for transfers. It was documented Tenant #8 had poor posture, poor coordination, and poor balance. After the evaluations, Tenant #8 had nine documented falls, one of which resulted in a head injury requiring staples. Medications for anxiety and depression were prescribed on 3-3-15. Staff interviews revealed Tenant #8 had declined over the last one to one and a half months and was routinely requiring two persons for transfer. The RN did not complete evaluations after 2-16-15. The service plan was not updated after 2-16-15. Tenant #8 was partially able to bear weight, was not able to demonstrate upper body strength, and did not follow instructions to move feet or hands. Tenant #8 resisted transfers and kept the buttocks out. Tenant #8 was observed to require assistance of two persons during observed transfers. Tenant #8 required routine two-person assistance for transfer for safety. 2. Tenant #10, an 88 year-old, was admitted on 7-25-14 and had diagnoses of: coronary artery	A 039		

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
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BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 039	Continued From page 35 disease, dementia, and hypertension. On 1-16-15 Tenant #10 was staged at four on the GDS which indicated moderate cognitive decline. According to the service (functional) evaluation completed 1-16-15, Tenant #10 ambulated short distances with a walker, a gait belt, and a staff member. The nurse (health) evaluation dated 1-16-15 documented Tenant #10 had poor coordination and poor balance. The service plan dated 1-16-15 documented staff were to follow with a wheelchair when Tenant #10 was ambulating, and assist of one was needed for transfer. A 90-day nurse review dated 1-16-15 documented in the progress notes revealed in early November Tenant #10 was ill, ate very little and stayed in bed. It was documented Tenant #10 was weaker at that point and began to lose weight. Tenant #10 had stopped ambulating and no longer took self to the bathroom. At the time of the nurse review, Tenant #10 was now ambulating short distances with staff, walker, and gait belt. Tenant #10 had received physical therapy (PT) but was discharged from PT on 1-16-15. Staff B was interviewed on 3-24-15 at 1:10 p.m. and stated Tenant #10 used the grab bar in the bathroom to transfer with the assist of one staff. Staff B reported Tenant #10 talked to the television, and was "very" incontinent through the night. Staff C was interviewed on 3-25-15 at 9:41 a.m. Staff C stated Tenant #10 required the assist of two persons 60-70% of the time. It was routine to use two persons to transfer Tenant #10.	A 039		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 039	Continued From page 36 Staff D was interviewed on 3-25-15 at 10:19 a.m. and stated Tenant #10 sometimes had good days. On other days, Tenant #10 would scream, was afraid and confused. Staff D reported Tenant #10 was always a two-person transfer in the morning, and required two persons 60% of the time during the rest of the day. Tenant #10 was incontinent and did not always tell staff when the bathroom was needed. Staff E was interviewed on 3-24-15 at 2:19 p.m. and stated Tenant #10 always required the assist of two persons to transfer the first of the day. Staff E used two persons to transfer Tenant #10. Staff F was interviewed on 3-25-15 at 8:44 a.m. and stated Tenant #10 required the assist of two persons for transfer. Staff F stated Tenant #10 has had bad days since January, and had routinely required the assist of two, at least 75 % of the time, for the last four to six weeks. The RN was interviewed on 3-25-15 at 12:40 p.m. and stated she looked at the ability to stand, balance, and pivot to determine the ability to transfer. The RN stated the tenant must be able to balance and could use a walker for that balance. On 3-25-15 at 11:42 a.m. Staff C and D entered Tenant #10's apartment. Tenant #10 was sitting in the recliner and leaning to the left side. Tenant #10 leaned forward for the application of a gait belt. Staff gave Tenant #10 instructions to stand up, and sit in the wheelchair. A count of three was given. Tenant #10 began yelling. As Tenant #10 was being transferred, Tenant #10 remained in a sitting position with the buttocks out. There was no obvious weight bearing to the legs and only one foot was on the ground during transfer.	A 039		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 039	Continued From page 37 The legs twisted as Tenant #10 was transferred from the chair to wheelchair. Staff C and D transferred Tenant #10 from the chair to the wheelchair. Tenant #10 was wheeled into the bathroom of the apartment. With staff direction, Tenant #10 grabbed the bar by the toilet. Staff removed the pants. Tenant #10 was attempting to sit while the pants were removed. Tenant #10 was not over the toilet at the time of sitting. Both staff pivoted Tenant #10 to the toilet. Staff C reported a foot rest was used when Tenant #10 was seated on the toilet because Tenant #10 had a fear of falling. PT instructed staff to use the foot rest. At 11:51 a.m., Staff C and D lifted Tenant #10 from the toilet. Tenant #10 remained in a seated position. Staff C and D used the gait belt for transfer from the toilet to the wheelchair. Both stated Tenant #10 would have fallen if they had let go of the gait belt. On 3-25-15 at 12:40 p.m. the RN was notified by the monitor that Tenant #10 had been observed for transfers and took two persons for transfers. The RN stated the staff had not notified her that Tenant #10 required the assistance of two persons for transfer. On 3-25-15 at 2:45 p.m. Staff B was observed with Tenant #10. Tenant #10 was in the wheelchair and was taken to the bathroom. A gait belt was not used despite the direction on the service plan to do so. Staff B instructed Tenant #10 to hang onto the grab bar. Staff B physically directed Tenant #10's hands to the grab bar. Tenant #10 was instructed to put feet on the floor	A 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0024	A BUILDING: _____ B WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

(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 039	Continued From page 38	A 039		

and stand. Tenant #10 stated "I can't." Tenant #10 was given the count of three to stand, and the bar was grabbed. Staff B used the hands at the hips and assisted Tenant #10 to stand. Tenant #10 was upright but fell backwards and was unsteady on the feet. Tenant #10 was pivoted to the toilet.

Tenant #10 was sitting on the toilet. Tenant #10 twisted at the waist to grab the bar located next to the toilet after instructed by Staff B. The feet were forward, but the upper body was twisted, and the buttocks were out as in a seated position. Tenant #10 did not stand straight. As the incontinence product was pulled up, Tenant #10 sat down. Tenant #10 was asked to stand up. Again the upper body was twisted to grab the bar. Staff B used the pants to lift Tenant #10. Tenant #10 remained in a seated position and did not stand upright. Tenant #10 was pivoted to the wheelchair. Tenant #10 was asked by Staff B to push self back in the wheelchair. Tenant #10 did not have the upper body strength to push self back in the wheelchair without assistance. Staff B reported the wheelchair was used for mobility.

On 3-26-15 at 9:07 a.m. Staff C and D were observed with Tenant #10 who was in a wheelchair. The gait belt was applied by Staff D. Tenant #10 was taken into the bathroom. Tenant #10 was instructed to grab the bar. The hands went to the rail, but the buttocks were kept out as in a seated position. Staff C and D were holding onto Tenant #10 with the gait belt. Staff C stated Tenant #10 would fall if not holding onto the gait belt. Tenant #10 sat down. A second attempt was made. Tenant #10 again kept the buttocks out while using the grab bar. Both staff were hanging onto the gait belt. Both staff removed the pants and Tenant #10 was pivoted to the

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
	S0024	A. BUILDING _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 039	Continued From page 39 toilet. Staff C and D stated it took two persons to transfer Tenant #10 most of the time. Tenant #10 had PT, but has declined since that time. It was reported PT services ended about two months earlier. Staff C stated she had gotten Tenant #10 up one time since Christmas using only one person for assistance. At 9:17 a.m. Tenant #10 stated "where are we?" Tenant #10 was prompted to stand and to use the grab bar. Tenant #10 kept the buttocks out but is pushing backwards. Staff C stated Tenant #10 would fall if she let go. Tenant #10 attempted to sit when the wheelchair was not behind the legs. Tenant #10 was hollering during the transfer. At 9:20 a.m. Tenant #10 was transferred from the wheelchair to the chair with assistance from Staff C and D. Tenant#10 was pivoted with the assist of the two staff. It was reported Tenant #10 only did "a little" weight bearing on the legs. Tenant #10 was too afraid of falling to assist according to the staff. On 3-30-15 at 10:49 a.m. Staff B and C were observed with Tenant #10. Tenant #10 was in the wheelchair and transferred from the dining room to the bathroom in the apartment. A gait belt was not applied. Tenant #10 was cued to grab the bar next to the toilet. Hands were guided to the bar. Tenant #10 stood up but remained in a seated position. Tenant #10 began hollering and sitting. Staff B pivoted Tenant #10 to the toilet. The incontinence products had not yet been removed. Staff B reported Tenant #10 began to drop and she pivoted Tenant #10 to the toilet. The incontinence products were removed while Tenant #10 was seated on the toilet.	A 039		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 039	Continued From page 40 At 10:54 a.m. Tenant #10 was hollering and stated "I can't sit here!" Tenant #10 leaned forward and grabbed the bar. Tenant #10 was unable to pull self up from the toilet. Tenant #10 remained in a seated position while being supported by staff. Staff B pulled up pants. Tenant #10 was attempting to sit while the pants were being pulled up. Tenant #10 was pivoted to the wheelchair. On 3-30-15 at 10:15 the RN was interviewed and asked if she had been in to evaluate Tenant #10 since the monitor reported observations of two-person transfers on 3-25-15. The RN stated she had spoken with Staff B who had transferred Tenant #10 with an assist of one afterwards. The RN stated Tenant #10 had not been evaluated. Tenant #10 was observed on several occasions over several days. Tenant #10 did not demonstrate adequate lower body strength to stand or balance and was not able to bear full weight on the legs. Tenant #10 had limited strength in the upper extremities. Tenant #10 was not cognitively able to follow directions as evidenced by continually remaining in a seated position and attempting to sit with no seat underneath. Tenant #10 resisted transfer by hollering "I can't!" Tenant #10 required the assistance of two persons for transfer for safety during all observations. Evaluations for Tenant #10 were completed on 1-16-15 immediately following the completion of PT and revealed Tenant #10 had poor coordination and poor balance. The service plan dated 1-16-15 documented staff were to follow with a wheelchair when Tenant #10 was ambulating, and assist of one was needed for	A 039		

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	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 039	Continued From page 41 transfer. The RN was informed on 3-25-15 that Tenant #10 had been observed to require the assistance of two for transfer. The RN stated Tenant #10 was not evaluated but relied upon information from an unlicensed staff member to determine Tenant #10's ability to transfer safely. Evaluations were not completed with a change of condition. Tenant #10 was partially able to bear weight and was not able to demonstrate upper body strength. Tenant #10 resisted transfers, was calling out, and kept the buttocks out. Tenant #10 did not follow instructions to stand, and sat at will. Tenant #10 was observed to require assistance of two persons during observed transfers. Tenant #10 required routine two-person assistance for transfer for safety.	A 039		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and observations, service plans were not based on	A 083		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 083	Continued From page 42 evaluations, and did not meet the specific service needs of individual tenants. Service plans were not updated when changes were needed. 1. Tenant #2, an 87 year-old, was admitted on 11-10-14 and had diagnoses of: chronic gouty arthritis, peripheral edema, skin infection, hypertension, carotid artery disease, and dementia. On 3-4-15 Tenant #2 was staged at five on the GDS which indicated moderately severe cognitive decline. An incident report dated 12-2-14 and timed 8:00 p.m. documented Tenant #2 admitted to slapping another tenant. Further documentation on the incident report revealed this was not new behavior, as family reported this behavior happened before. The incident also documented Tenant #2 had "as needed" medication for agitation. The service plans dated 11-1-14, current at the time of the incident, included interventions for wandering but was not updated with interventions for tenant-on-tenant aggression, or direct staff on the use of the "as needed" medication for agitation. The 90-day nurse review documented in the progress notes dated 3-4-15 identified "resident encounters" continued to resolve. The 90-day nurse review did not identify the behaviors had been eliminated. The service plan of 3-4-15 was not updated with interventions for tenant-on-tenant aggression or direct staff on the use of "as needed" medication for agitation. An order written by the healthcare provider on 1-6-15 documented Tenant #2 had open areas under an abdominal fold and treatment was	A 083		

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
	S0024	A. BUILDING _____ B. WING _____	C 03/30/2015

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BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 083	Continued From page 43 ordered. The order included using "whatever works" to keep the skin surfaces from rubbing together. The Program provided a copy of the physician's orders dated 3-2-15 and signed by the RN. It was reported orders were sent to the physician regularly to keep the orders current. The treatment orders for the open areas under the abdominal fold were on the order list for 3-2-15. The service plan dated 3-4-15 did not identify Tenant #2 had a history of open areas on the skin, did not identify signs or symptoms for staff to report to the nurse. The service plans were not updated and did not meet the identified needs of Tenant #2. 2. Tenant #8, an 88 year-old, was admitted on 12-31-12 and had diagnoses of: atrial fibrillation, dementia, history of bilateral knee replacements, and Parkinson's disease. On 2-16-15 Tenant #8 was staged at three on the Global Deterioration Scale (GDS) which indicated mild cognitive decline. According to progress notes dated 2-16-15, Parkinson's disease continued to change Tenant #8's strength. Tenant #8 required assist of one and ambulated with a walker. Tenant #8 was exhibiting weight loss. Tenant #8 preferred staying in the apartment and napping rather than attending activities. Evaluations of function, cognition, and health were completed. A lift chair was put in place following falls from getting in and out of a recliner. The service (functional) evaluation dated 2-16-15 and completed by the RN revealed Tenant #8	A 083		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 083	Continued From page 44 needed reminders for meal times and documented Tenant #8 sometimes had difficulty sitting down at the table. Staff was to assist as needed. The service evaluation also documented Tenant #8 had increased one-sided weakness for which Tenant #8 required assistance in dressing. The service evaluation documented Tenant #8 could ambulate with a walker to the bathroom, with assist of one to two for escort. A gait belt could be used. Tenant #8 could hold onto the grab bar by the toilet and pivot to sit with staff assist. The service evaluation documented Tenant #8 used a walker for ambulation, and staff provided assistance with gait belt and hands-on assist for safety. The evaluation documented Tenant #8 was getting weaker. A wheelchair was used when Tenant #8 was unable to ambulate safely. The service evaluation documented the family found it increasingly difficult to take Tenant #8 out of the building for doctor visits. It was documented Tenant #8 was disoriented and needed reminders of the daily routine. The nurse (health) evaluation dated 2-16-15 and completed by the RN documented Tenant #8 complained of numbness, possibly attributed to the Parkinson's disease. The left shoulder and elbow were stiff and the hand shook at times. It was documented Tenant #8 was often unable to successfully use the left arm. It was documented Tenant #8 had moderate limited range of motion of the lower extremities, and that a Parkinson's gait was becoming more apparent. It was documented Tenant #8 had poor posture, poor coordination, and poor balance. Incident reports documented the following nine events for Tenant #8: 2-20-15 at 7:00 a.m. fall while attempting to sit on	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

(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 083	Continued From page 45 shower chair, skin tear left elbow. As needed Ativan had been given twice during the night for restlessness. 2-20-15 at 6:00 p.m. raised electric chair and slid to floor. Tenant #8 reminded to call staff for assist. 2-23-15 at 1:15 a.m. fell attempting to get out of bed, skin tear to right elbow. Staff to bring urinal to bed 2-23-15 at 3:00 a.m. attempting to use urinal, caught in walker with backside up in air as the walker was flipped and holding legs up. Removed walker from bedside to avoid repeat incident. Progress notes dated 2-23-15 and timed 9:00 a.m. documented Tenant #8 was restless and "as needed" Ativan gave temporary rest. A nighttime sleep aid was not recommended by the physician. The RN documented the nurse practitioner would be consulted for suggestions. 2-23-15 at 7:45 p.m. got up on own to use restroom, lost balance, and fell. 3-1-15 at 7:00 p.m. fell while walking back from bathroom. Had left elbow and back pain. Notification to the physician documented Tenant #8 later stated the head was hit during the fall. Progress notes dated 3-3-15 and timed at 12:05 p.m. documented Ativan (for anxiety) and Lexapro (antidepressant) were to be given daily 3-6-15 at 2:15 p.m. walking to the bathroom with two staff, Tenant #8's legs did not hold, Tenant #8 was lowered to the floor. Documentation on the incident report completed by the RN indicated the family was consulted about possible interventions of private duty caregiver, pillows for comfort in	A 083		

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
	S0024	A BUILDING: _____ B WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 083	Continued From page 46 bed, shower chair on rollers, and a bedside commode. The family was considering the interventions. 3-7-15 at 2:44 a.m. found on floor with head on table. Bleeding from right side of head. 911 called. Documentation from the hospital dated 3-7-15 revealed Tenant #8 had scans of the neck, head, and pelvis, and X-rays of the chest, arm, pelvis, and wrist. Staples were used on the head wound. 3-8-15 at 11:15 a.m. Tenant #8 yelling, found on floor, reported falling as legs gave out when leaving bathroom. Tenant #8 struggled to stand up even with two staff. Tenant #8 was resisting. Small cut on wrist. The record lacked documentation of evaluations of function, cognition, and health following multiple falls, and one with a head injury severe enough to require evaluation at a hospital and staples to the head. Evaluations were not completed with significant changes in condition. The service plan current at the time of the onsite visit was dated 2-16-15 and had not been updated with interventions following multiple falls, one of which included a head injury. The service plan did not direct staff to the care of the staples in the head during bathing. On 3-24-15 at 1:10 p.m. Staff B stated Tenant #8 had Parkinson's disease and had declined. Staff B stated Tenant #8 routinely required two staff for transfer and was frequently incontinent. On 3-25-15 at 9:41 a.m. Staff C stated Tenant #8 could not stand. Tenant #8 required two persons for transfer 100% of the time, and sometimes	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0024	A. BUILDING _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

(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 083	Continued From page 47 took three persons for transfer. Staff C reported Tenant #8 did not walk. Tenant #8 was "stiff" but tried to move extremities to assist with dressing. On 3-25-15 at 10:19 a.m. Staff D stated Tenant #8 had required the assistance of two persons for transfers for the last one to one and a half months. Staff D stated Tenant #8 thought he/she was assisting by pushing up, but was really pushing down so as to resist transferring. Tenant #8 was described as "dead weight" who did not bear weight on the legs. Tenant #8 was reported to use the wheelchair and did not walk. Staff D reported Tenant #8's arms did not move a lot. The left arm needed to be moved manually by staff as Tenant #8 did not move the left arm. On 3-24-15 at 2:19 p.m. Staff E reported Tenant #8 routinely took two persons for transfer. On 3-25-15 at 8:44 a.m. Staff F reported Tenant #8 got bed baths as it was difficult to get Tenant #8 in and out of the whirlpool bath. Tenant #8 used a wheelchair for mobility, and transferred with the assist of two. Staff F reported it took three persons to dress Tenant #8, two to hold Tenant #8 and one to dress. Tenant #8 required assistance of two to transfer and used a commode and did not use the toilet. Staff F reported Tenant #8 had been a routine two-person transfer 100% of the time for four to six weeks. On 3-25-15 at 4:30 p.m. Staff G was interviewed and stated Tenant #8 had been declining for the last month. Staff G thought it was about the time the anti-anxiety medication was ordered. Staff G reported Tenant #8 thought objects were closer than they actually were, and Tenant #8 would try to sit even though the seat was not close. Tenant	A 083		

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
	S0024	A. BUILDING. _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

(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 083	Continued From page 48 #8 was weaker. The RN was interviewed on 3-25-15 at 12:40 p.m. and stated she looked at the ability to stand, balance, and pivot to determine the ability to transfer. The RN stated the tenant must be able to balance and could use a walker for that balance. The following observations were made: On 3-24-15 at 2:06 p.m. Tenant #8 was in the common area in a wheelchair. Staff B propelled Tenant #8 in the wheelchair to the apartment. The left arm appeared immobile. Staff E came in to assist. A gait belt was applied. Tenant #8's hands were guided to walker. The staff grabbed the gait belt. Tenant #8 used the legs very little to lift. The buttocks remained out, and Tenant #8 did not stand upright. The left hand did not grip the walker. The staff members attempted to pivot Tenant #8 to the chair. The walker tipped, but Staff B and E were able to get Tenant #8 into the chair. Staff E stated Tenant #8 did not stand upright often, and did not use the left arm. Staff E stated Tenant #8 was mostly a two person transfer 75 to 90% of the time. On 3-25-15 at 11:35 a.m. in Tenant #8's apartment with Staff C And D. Tenant #8 was in the lift chair and the lift chair was raised to the upright position. A gait belt was applied, and staff counted to three to lift. Tenant #8 pushed backwards and the buttocks was out. Tenant #8 was working against the transfer. Tenant #8 was transferred to the wheelchair that was on the left side, Tenant #8's weaker side. On 3-25-15 at 4:40 p.m. Staff G was observed during the transfer of Tenant #8. Tenant #8 was in the apartment and the lift chair was elevated.	A 083		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

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BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 083	Continued From page 49 Tenant #8 was asked to use the walker to hold onto to stand to that pants could be changed. The left hand did not grip the walker firmly. The left hand was shaking. Tenant #8 was leaning to the left. Tenant #8 raised the buttocks from the chair but was pressing backwards. The pants were removed. Tenant #8 did not reposition the feet upon request of Staff G. Staff G manually repositioned the feet. Once the pants were changed the gait belt was applied. The walker was positioned again in front of the lift chair and the wheelchair was to the left. Tenant #8 was instructed to stand up tall. Tenant #8 raised the buttocks from the raised lift chair but is pushing backwards. Staff G was providing a grip to the gait belt. Tenant #8 was asked to walk forward, but was unable to move the feet. Staff G moved the walker forward and Tenant #8 took tiny steps. Tenant #8 began to lean, but was not moving in the direction of the wheelchair. Staff G moved Tenant #8 to the wheelchair. Staff G was in a crouched position with arms outstretched at the end of the transfer. Staff G confirmed that Tenant #8 did not pivot into the wheelchair. Tenant #8 was asked to lift the feet to put them in the footrests on the wheelchair. Tenant #8 could not put the feet on the footrests and Staff G had to do it manually. Staff G asked Tenant #8 to use the arm to push self in the wheelchair to reposition. Tenant #8 was unable to reposition self in the wheelchair so Staff G came from behind to raise Tenant #8 from the back, using the gait belt. On 3-26-15 at 11:37 a.m. Staff B and C were in Tenant #8's apartment. Tenant #8 was in the lift chair and the lift chair was raised to the upright position. A gait belt was applied. Staff counted to lift. Tenant #8's upper extremities were shaking and Tenant #8 pushed back in the opposite direction according to Staff B and C. Staff C	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0024	A. BUILDING _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

(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 083	Continued From page 50 reported Tenant #8 did not use the bathroom but used the commode that was observed to be present in the apartment. Staff C reported Tenant #8 had required two persons for transfer for the last one to one and a half months. On 3-30-15 at 11:32 a.m. Staff C and Staff F were in Tenant #8's apartment. The lift chair was raised and the gait belt was applied. One staff member was under each arm. After counting, Staff C and F raised Tenant #8 and transferred Tenant #8 to the wheelchair positioned to the left of the lift chair. Tenant #8 pushed backwards and kept the buttocks out. Tenant #8 was asked if it always took to people to get Tenant #8 into the chair; Tenant #8 replied "yes." Tenant #8 was observed on several occasions over several days. Tenant #8 did not demonstrate adequate lower body strength to stand or balance and was not able to bear full weight on the legs. Tenant #8 had limited strength in the upper extremities as well as shaking of the upper extremities, and although cognitively able, was not physically able to follow directions to move feet or arms. Tenant #8 resisted transfer by pushing backwards, and kept the buttocks out, and would lean to one side. Tenant #8 required the assistance of two persons for transfer for safety during all observations. The service plan was completed for Tenant #8 on 2-16-15. The service plan did not identify Tenant #8 was no longer ambulating, but was using a wheelchair for transportation. The service plan did not identify the use of the commode for toileting. The service plan did not identify interventions for falls. The service plan did not identify care of the staples in the head during bathing. The service plan did not identify	A 083		

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	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

(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 083	Continued From page 51 interventions for anxiety and sleepless nights or direct staff on the use of "as needed" medications for anxiety. The service plan was not updated to meet the specific service needs of Tenant #8. 3. Tenant #9, a 90 year-old, was admitted on 6-24-13 and had diagnoses of: dementia and hypertension. On 2-25-15 Tenant #9 was staged at five on the GDS which indicated moderately severe cognitive decline. A 90-day nurse review was completed on 2-25-15. The progress notes documented physical therapy (PT) was discontinued on 12-11-14. The service plan dated 2-25-15 documented Tenant #9 was receiving PT services. The service plan was not updated with the changes to services. The nurse (health) evaluation completed 2-25-15 documented Tenant #9's skin condition was normal. The service plan of the same date documented the only treatment was support stockings. Progress notes dated 3-3-15 documented an order was received to cleanse a left hip wound thoroughly and to obtain a culture of the wound. Twice a day dressings were ordered. The service plan of 2-25-15 was not updated to identify a left hip wound, did not identify care of the wound during bathing, and did not give direction to staff of signs and symptoms to report to the nurse. The service plan was not updated with changes to meet the needs of Tenant #9. 4. Tenant #10, an 88 year-old, was admitted on 7-25-14 and had diagnoses of: coronary artery disease, dementia, and hypertension. On 1-16-15 Tenant #10 was staged at four on the GDS which indicated moderate cognitive decline.	A 083		

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
	S0024	A. BUILDING _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 083	Continued From page 52 According to the service (functional) evaluation completed 1-16-15, Tenant #10 ambulated short distances with a walker, a gait belt, and a staff member. The nurse (health) evaluation dated 1-16-15 documented Tenant #10 had poor coordination and poor balance. The service plan dated 1-16-15 documented staff were to follow with a wheelchair when Tenant #10 was ambulating, and assist of one was needed for transfer. A 90-day nurse review dated 1-16-15 documented in the progress notes revealed in early November Tenant #10 was ill, ate very little and stayed in bed. It was documented Tenant #10 was weaker at that point and began to lose weight. Tenant #10 had stopped ambulating and no longer took self to the bathroom. At the time of the nurse review, Tenant #10 was now ambulating short distances with staff, walker, and gait belt. Tenant #10 had received physical therapy (PT) but was discharged from PT on 1-16-15. Staff B was interviewed on 3-24-15 at 1:10 p.m. and stated Tenant #10 used the grab bar in the bathroom to transfer with the assist of one staff. Staff B reported Tenant #10 talked to the television, and was "very" incontinent through the night. Staff C was interviewed on 3-25-15 at 9:41 a.m. Staff C stated Tenant #10 required the assist of two persons 60-70% of the time. It was routine to use two persons to transfer Tenant #10. Staff D was interviewed on 3-25-15 at 10:19 a.m. and stated Tenant #10 sometimes had good days. On other days, Tenant #10 would scream,	A 083		

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	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 083	Continued From page 53 was afraid and confused. Staff D reported Tenant #10 was always a two-person transfer in the morning, and required two persons 60% of the time during the rest of the day. Tenant #10 was incontinent and did not always tell staff when the bathroom was needed. Staff E was interviewed on 3-24-15 at 2:19 p.m. and stated Tenant #10 always required the assist of two persons to transfer the first of the day. Staff E used two persons to transfer Tenant #10. Staff F was interviewed on 3-25-15 at 8:44 a.m. and stated Tenant #10 required the assist of two persons for transfer. Staff F stated Tenant #10 has had bad days since January, and has routinely required the assist of two, at least 75 % of the time, for the last four to six weeks. The RN was interviewed on 3-25-15 at 12:40 p.m. and stated she looked at the ability to stand, balance, and pivot to determine the ability to transfer. The RN stated the tenant must be able to balance and could use a walker for that balance. On 3-25-15 at 11:42 a.m. Staff C and D entered Tenant #10's apartment. Tenant #10 was sitting in the recliner and leaning to the left side. Tenant #10 leaned forward for the application of a gait belt. Staff gave Tenant #10 instructions to stand up, and sit in the wheelchair. A count of three was given. Tenant #10 began yelling. As Tenant #10 was being transferred, Tenant #10 remained in a sitting position with the buttocks out. There was no obvious weight bearing to the legs and only one foot was on the ground during transfer. The legs twisted as Tenant #10 was transferred from the chair to wheelchair. Staff C and D transferred Tenant #10 from the chair to the	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

(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 083	Continued From page 54 wheelchair. Tenant #10 was wheeled into the bathroom of the apartment. With staff direction, Tenant #10 grabbed the bar by the toilet. Staff removed the pants. Tenant #10 was attempting to sit while the pants were removed. Tenant #10 was not over the toilet at the time of sitting. Both staff pivoted Tenant #10 to the toilet. Staff C reported a foot rest was used when Tenant #10 was seated on the toilet because Tenant #10 had a fear of falling. PT instructed staff to use the foot rest. At 11:51 a.m., Staff C and D lifted Tenant #10 from the toilet. Tenant #10 remained in a seated position. Staff C and D used the gait belt for transfer from the toilet to the wheelchair. Both stated Tenant #10 would have fallen if they had let go of the gait belt. On 3-25-15 at 12:40 p.m. the RN was notified by the monitor that Tenant #10 had been observed for transfers and took two persons for transfers. The RN stated the staff had not notified her that Tenant #10 required the assistance of two persons for transfer. On 3-25-15 at 2:45 p.m. Staff B was observed with Tenant #10. Tenant #10 was in the wheelchair and was taken to the bathroom. A gait belt was not used despite the direction on the service plan to do so. Staff B instructed Tenant #10 to hang onto the grab bar. Staff B physically directed Tenant #10's hands to the grab bar. Tenant #10 was instructed to put feet on the floor and stand. Tenant #10 stated "I can't." Tenant #10 was given the count of three to stand, and the bar was grabbed. Staff B used the hands at	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0024	A. BUILDING _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

(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 083	Continued From page 55 the hips and assisted Tenant #10 to stand. Tenant #10 was upright but fell backwards and was unsteady on the feet. Tenant #10 was pivoted to the toilet. Tenant #10 was sitting on the toilet. Tenant #10 twisted at the waist to grab the bar located next to the toilet after instructed by Staff B. The feet were forward, but the upper body was twisted, and the buttocks were out as in a seated position. Tenant #10 did not stand straight. As the incontinence product was pulled up, Tenant #10 sat down. Tenant #10 was asked to stand up. Again the upper body was twisted to grab the bar. Staff B used the pants to lift Tenant #10. Tenant #10 remained in a seated position and did not stand upright. Tenant #10 was pivoted to the wheelchair. Tenant #10 was asked by Staff B to push self back in the wheelchair. Tenant #10 did not have the upper body strength to push self back in the wheelchair without assistance. Staff B reported the wheelchair was used for mobility. On 3-26-15 at 9:07 a.m. Staff C and D were observed with Tenant #10 who was in a wheelchair. The gait belt was applied by Staff D. Tenant #10 was taken into the bathroom. Tenant #10 was instructed to grab the bar. The hands went to the rail, but the buttocks were kept out as in a seated position. Staff C and D were holding onto Tenant #10 with the gait belt. Staff C stated Tenant #10 would fall if not holding onto the gait belt. Tenant #10 sat down. A second attempt was made. Tenant #10 again kept the buttocks out while using the grab bar. Both staff were hanging onto the gait belt. Both staff removed the pants and Tenant #10 was pivoted to the toilet. Staff C and D stated it took two persons to	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

(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 083	Continued From page 56	A 083		

transfer Tenant #10 most of the time. Tenant #10 had PT, but has declined since that time. It was reported PT services ended about two months earlier. Staff C stated she had gotten Tenant #10 up one time since Christmas using only one person for assistance.

At 9:17 a.m. Tenant #10 stated "where are we?" Tenant #10 was prompted to stand and to use the grab bar. Tenant #10 kept the buttocks out but is pushing backwards. Staff C stated Tenant #10 would fall if she let go. Tenant #10 attempted to sit when the wheelchair was not behind the legs. Tenant #10 was hollering during the transfer.

At 9:20 a.m. Tenant #10 was transferred from the wheelchair to the chair with assistance from Staff C and D. Tenant#10 was pivoted with the assist of the two staff. It was reported Tenant #10 only did "a little" weight bearing on the legs. Tenant #10 was too afraid of falling to assist according to the staff.

On 3-30-15 at 10:49 a.m. Staff B and C were observed with Tenant #10. Tenant #10 was in the wheelchair and transferred from the dining room to the bathroom in the apartment. A gait belt was not applied. Tenant #10 was cued to grab the bar next to the toilet. Hands were guided to the bar. Tenant #10 stood up but remained in a seated position. Tenant #10 began hollering and sitting. Staff B pivoted Tenant #10 to the toilet. The incontinence products had not yet been removed. Staff B reported Tenant #10 began to drop and she pivoted Tenant #10 to the toilet. The incontinence products were removed while Tenant #10 was seated on the toilet.

At 10:54 a.m. Tenant #10 was hollering and stated "I can't sit here!" Tenant #10 leaned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0024	A. BUILDING. _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 083	Continued From page 57 forward and grabbed the bar. Tenant #10 was unable to pull self up from the toilet. Tenant #10 remained in a seated position while being supported by staff. Staff B pulled up pants. Tenant #10 was attempting to sit while the pants were being pulled up. Tenant #10 was pivoted to the wheelchair. On 3-30-15 at 10:15 the RN was interviewed and asked if she had been in to evaluate Tenant #10 since the monitor reported observations of two-person transfers on 3-25-15. The RN stated she had spoken with Staff B who had transferred Tenant #10 with an assist of one afterwards. The RN stated Tenant #10 had not been evaluated. Tenant #10 was observed on several occasions over several days. Tenant #10 did not demonstrate adequate lower body strength to stand or balance and was not able to bear full weight on the legs. Tenant #10 had limited strength in the upper extremities. Tenant #10 was not cognitively able to follow directions as evidenced by continually remaining in a seated position and attempting to sit with no seat underneath. Tenant #10 resisted transfer by hollering "I can't!" Tenant #10 required the assistance of two persons for transfer for safety during all observations. The service plan was not updated with a change of condition to include the use of the wheelchair for all mobility and two persons for transfer. The nurse (health) evaluation dated 1-16-15 dated 1-16-15 identified Tenant #10 experienced weight loss and a nutritional program had been implemented. The service plan was not based on the evaluation and of 1-16-15 did not identify the nutritional program.	A 083		

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
	S0024	A. BUILDING. _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 083	Continued From page 58 The progress notes dated 2-20-15 documented Tenant #10 was to be given a pain reliever with food early in the morning 30 to 45 minutes prior to getting out of bed, so that Tenant #10 would be more comfortable and cooperative. The service plan did not include the identified intervention for pain and mobility. The service plan was not based on the evaluation and did not meet the identified needs of Tenant #10. 5. Tenant #11, an 87 year-old, was admitted on 8-18-14 and had diagnoses of: chronic inflammatory demyelinating polyneuropathy, benign prostatic hypertrophy, and atrial fibrillation. On 12-12-14 Tenant #11 was staged at one on the GDS which indicated no cognitive decline. Progress notes dated 3-2-15 documented Tenant #11 was sent to the hospital for a decline in condition and did not return to the Program. The treatment record for December 2014 documented Tenant #11 required barrier cream to a coccyx wound, Nystatin to an affected area, treatment to a big toe and upper arm. The treatment record identified Tenant #11 had a history of skin breakdown. On 12-4-14, Tenant #11 was admitted to the hospital for acute pharyngitis. According to the documentation from the hospital, Tenant #11 had several days of sore throat and increasing difficulty swallowing with a history of vomiting. Tenant #11 arrived at the hospital via ambulance. The hospital documentation documented Tenant #11 had a sore throat secondary to severe pharyngitis with impending airway obstruction. Tenant #11 was admitted to the intensive care unit. Tenant #11 also was diagnosed with pneumonia.	A 083		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

(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 083	Continued From page 59 Progress notes dated 12-18-14 documented Tenant #11 went to the hospital by ambulance and returned the same day with an order for a hospital bed and an antibiotic for 10 days. A progress note from the physician dated 12-22-14 documented Tenant #11 was seen in the emergency room on 12-18-14 and diagnosed with acute bronchitis. The physician documented Tenant #11 struggled chronically with breathing when lying flat on the back. A hospital bed was ordered to keep the head of the bed elevated secondary to gastroesophageal reflux disease. The physician documented Tenant #11 did no move independently and required transfers. Tenant #11 was noted to be at risk for skin breakdown. The physician documented Tenant #11 required a hospital bed as a medical necessity to assist Tenant #11 with breathing, swallowing, and ridding self of respiratory secretions. An air mattress was recommended to prevent skin breakdown. The RN noted the documentation on 1-13-15. A speech therapist documented on 1-15-15 it was recommended pills be placed in pudding or applesauce. The therapist would see Tenant #11 for difficulty swallowing. Speech therapy notes dated 1-20-15 documented Tenant #11 demonstrated overt signs and symptoms of aspiration with meals. The therapist documented Tenant #11 had not received a handled cup at meals and medications were not given in applesauce as recommended. Therapy notes dated 1-27-15 documented the therapist continued to be concerned about aspiration. The service plan of 12-12-14 was not updated	A 083		

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
	S0024	A. BUILDING _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 083	Continued From page 60 with changes of condition to identify interventions for skin breakdown , the use of the hospital bed, and signs and symptoms of breathing difficulty for staff to report to the nurse. The service plan did not identify interventions for swallowing difficulties and did not identify Tenant #11 as prone to aspiration. The service plan was not updated to meet the identified needs of Tenant #11. 6. Tenant #12, a 90 year-old, was admitted on 10-9-10 and had diagnoses of: gastroesophageal reflux disease, diabetes, hypertension, osteoarthritis, hypertensive encephalopathy, and dementia. On 12-4-14 Tenant #12 was staged at three on the GDS which indicated mild cognitive decline. The service (functional) evaluation dated 12-4-14 documented Tenant #12 required escorts to and from activities and meals. The evaluation revealed a gait belt was to be used for all transfers and a slide board was available as needed. The service plan of 12-4-14 reflected the functional evaluation. The nurse (health) evaluation of 12-4-14 documented Tenant #12 had severely limited range of motion to both upper and lower extremities. Tenant #12 had poor posture, poor coordination, and poor balance. Tenant #12 was unable to bear weight. Progress notes dated 11-4-14 timed 9:30 a.m. documented Tenant #12 was on the toilet when Tenant #12 slumped and the head rolled, making "gutteral" noises. Notes documented Tenant #12 had experienced similar episodes several times, usually when on the toilet. The progress notes dated 12-4-14 documented these episodes	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 083	Continued From page 61 resembled a Vagal response. The service plan of 12-4-14 did not identify Tenant #12 experienced frequent Vagal responses. The service plan did not give direction to staff to care for Tenant #12 during a Vagal response. Progress notes of 12-4-14 documented Tenant #12 had a steady weight loss over the previous months and hospice was being considered. Progress notes dated 12-16-14 and timed 2:17 p.m. documented Tenant #12 would be receiving "pre-hospice" care from a nurse practitioner. Progress notes dated 12-22-14 and 1-5 and 1-12-15 documented Tenant #12 slid out of a lift chair. Progress notes dated 1-17-15 and timed 4:55 a.m. documented Tenant #12 had expired. In an interview with the RN at exit, she stated Tenant #12 had declined just one or two days prior to death. The RN provided a delegation form for end of life care and stated she had prepared the information for staff use. The delegation form instructed every two hour checks for mouth care, perineal care, and repositioning. Staff B was interviewed on 3-24-15 at 1:10 p.m. and stated Tenant #12 always took two to transfer for "quite a long time, several weeks." Tenant #12 was incontinent and was usually wet. Tenant #12 was bedbound the last week of life. Staff C was interviewed on 3-25-15 at 9:41 a.m. and stated Tenant #12 was a two-person assist since last fall.	A 083		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 083	Continued From page 62 Staff D was interviewed on 3-25-15 at 10:19 a.m. and stated Tenant #12 started sleeping all the time and was bedbound the last month of life. Staff E was interviewed on 3-24-15 at 2:19 p.m. and stated Tenant #12 required two persons for transfer for weeks or months. Staff F was interviewed on 3-25-15 at 8:44 a.m. and stated Tenant #12 required two persons for transfer 100% of the time the last month of life. Tenant #12 was incontinent and sometimes needed assistance to eat. The service plan of 12-4-15 did not identify interventions for weight loss, did not identify the number of staff members neededfor safely transferring Tenant #12, and was not updated with interventions for end of life care. The service plan dated 12-4-14 was not updated to meet the identified needs of Tenant #12.	A 083		
A 084	481-69.26(2) Service Plans 481-69.26(231C) Service plans. 69.26(2) Prior to the tenant ' s signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant ' s request, with other individuals identified by the tenant, and, if applicable, with the tenant ' s legal representative. All persons who develop the plan and the tenant or the tenant ' s legal representative shall sign the plan.	A 084		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 084	Continued From page 63 This REQUIREMENT is not met as evidenced by: Based on record review which included a review of occupancy agreements, service plans were not developed in consultation with the tenant prior to the signing of the occupancy agreement. Two new tenant records were reviewed. 1. Tenant #1 signed occupancy agreement on 1-29-15. The agreement stated the rental agreement began on 1-29-15. The agreement also stated the service agreement which contained the service plan was used to establish the level of services required and the rates. Tenant #1 signed the service plan on 1-31-15. 2. The legal representative for Tenant #2 signed the occupancy agreement on 11-10-14. The agreement stated the rental agreement began on 11-10-14. The agreement also stated the service agreement which contained the service plan was used to establish the level of services required and the rates. The registered nurse signed the service plan on 11-11-14 and the legal representative signed on 11-12-14. Preliminary service plans were not developed prior to the signing of the occupancy agreement.	A 084		
A 096	481-69.27(3) Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant ' s condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse	A 096		

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 096	Continued From page 64 via nurse delegation: 69.27(3) To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant ' s health status This REQUIREMENT is not met as evidenced by: Based on record review, nurse reviews were not completed to assess and document the health status of each tenant and to monitor progress related to previous recommendations every 90 days and with changes of condition. Seven files were reviewed. 1. Tenant #8, an 88 year-old, was admitted on 12-31-12 and had diagnoses of: atrial fibrillation, dementia, history of bilateral knee replacements, and Parkinson's disease. On 2-16-15 Tenant #8 was staged at three on the Global Deterioration Scale (GDS) which indicated mild cognitive decline. According to progress notes dated 2-16-15, Parkinson's disease continued to change Tenant #8's strength. Tenant #8 required assist of one and ambulated with a walker. Tenant #8 was exhibiting weight loss. Tenant #8 preferred staying in the apartment and napping rather than attending activities. Evaluations of function, cognition, and health were completed. A lift chair was put in place following falls from getting in and out of a recliner. The service (functional) evaluation dated 2-16-15 and completed by the RN revealed Tenant #8 needed reminders for meal times and documented Tenant #8 sometimes had difficulty	A 096		

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
	S0024	A. BUILDING _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 096	Continued From page 65 sitting down at the table. Staff was to assist as needed. The service evaluation also documented Tenant #8 had increased one-sided weakness for which Tenant #8 required assistance in dressing. The service evaluation documented Tenant #8 could ambulate with a walker to the bathroom, with assist of one to two for escort. A gait belt could be used. Tenant #8 could hold onto the grab bar by the toilet and pivot to sit with staff assist. The service evaluation documented Tenant #8 used a walker for ambulation, and staff provided assistance with gait belt and hands-on assist for safety. The evaluation documented Tenant #8 was getting weaker. A wheelchair was used when Tenant #8 was unable to ambulate safely. The service evaluation documented the family found it increasingly difficult to take Tenant #8 out of the building for doctor visits. It was documented Tenant #8 was disoriented and needed reminders of the daily routine. The nurse (health) evaluation dated 2-16-15 and completed by the RN documented Tenant #8 complained of numbness, possibly attributed to the Parkinson's disease. The left shoulder and elbow were stiff and the hand shook at times. It was documented Tenant #8 was often unable to successfully use the left arm. It was documented Tenant #8 had moderate limited range of motion of the lower extremities, and that a Parkinson's gait was becoming more apparent. It was documented Tenant #8 had poor posture, poor coordination, and poor balance. Incident reports documented the following nine events for Tenant #8: 2-20-15 at 7:00 a.m. fall while attempting to sit on shower chair, skin tear left elbow. As needed Ativan had been given twice during the night for	A 096		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 096	Continued From page 66 restlessness. 2-20-15 at 6:00 p.m. raised electric chair and slid to floor. Tenant #8 reminded to call staff for assist. 2-23-15 at 1:15 a.m. fell attempting to get out of bed, skin tear to right elbow. Staff to bring urinal to bed 2-23-15 at 3:00 a.m. attempting to use urinal, caught in walker with backside up in air as the walker was flipped and holding legs up. Removed walker from bedside to avoid repeat incident. Progress notes dated 2-23-15 and timed 9:00 a.m. documented Tenant #8 was restless and "as needed" Ativan gave temporary rest. A nighttime sleep aid was not recommended by the physician. The RN documented the nurse practitioner would be consulted for suggestions. 2-23-15 at 7:45 p.m. got up on own to use restroom, lost balance, and fell. 3-1-15 at 7:00 p.m. fell while walking back from bathroom. Had left elbow and back pain. Notification to the physician documented Tenant #8 later stated the head was hit during the fall. Progress notes dated 3-3-15 and timed at 12:05 p.m. documented Ativan (for anxiety) and Lexapro (antidepressant) were to be given daily 3-6-15 at 2:15 p.m. walking to the bathroom with two staff, Tenant #8's legs did not hold, Tenant #8 was lowered to the floor. Documentation on the incident report completed by the RN indicated the family was consulted about possible interventions of private duty caregiver, pillows for comfort in bed, shower chair on rollers, and a bedside commode. The family	A 096		

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
	S0024	A. BUILDING _____ B. WING _____	C 03/30/2015

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BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 096	Continued From page 67 was considering the interventions. 3-7-15 at 2:44 a.m. found on floor with head on table. Bleeding from right side of head. 911 called. Documentation from the hospital dated 3-7-15 revealed Tenant #8 had scans of the neck, head, and pelvis, and X-rays of the chest, arm, pelvis, and wrist. Staples were used on the head wound. 3-8-15 at 11:15 a.m. Tenant #8 yelling, found on floor, reported falling as legs gave out when leaving bathroom. Tenant #8 struggled to stand up even with two staff. Tenant #8 was resisting. Small cut on wrist. On 3-7-15, Tenant #8 fell and sustained a cut to the head. Tenant #8 was sent to the hospital for evaluation and treatment. Progress notes dated 3-13-15 at 8:55 a.m. and documented as a late entry repeated the information staff provided. A nurse review was not completed on 3-7-14 to assess and document the heath status of Tenant #8 who sustained a head injury. A nurse review did not assess and document the status of the head wound. Progress notes dated 3-12-15 and timed 1:00 p.m. and as a late entry documented Tenant #8's family removed the staples from Tenant #8's head. A nurse review was not completed to assess and document the health status and to monitor progress related to the wound following removal of the staples. Progress notes dated 3-12-14 as a late entry for 3-6-15 following a fall documented the Program spoke to the family regarding interventions including private duty caregiver, pillows, and a rolling shower chair. A nurse review was not	A 096		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 096	Continued From page 68 completed to assess and document Tenant #8's health status and to monitor progress related to the recommendations. Progress notes dated 3-10-15 documented an order had been received to discontinue benzodiazepines; however, the family wanted to talk prior to the discontinuation of the medication due to concern about Tenant #8's anxiety and comfort. A nurse review was not completed to assess and document Tenant #8's health status and to monitor progress related to the family's decision regarding the benzodiazepines. 2. Tenant #2, an 87 year-old, was admitted on 11-10-14 and had diagnoses of: chronic gouty arthritis peripheral edema, skin infection, hypertension, carotid artery disease, and dementia. On 3-4-15 Tenant #2 was staged at five on the GDS which indicated moderately severe cognitive decline. An order written by the healthcare provider on 1-6-15 documented Tenant #2 had open areas under an abdominal fold and treatment was ordered. The order included using "whatever works" to keep the skin surfaces from rubbing together. The progress notes dated 1-6-15 documented the order was received but did not contain a nurse review to assess and document the health status of Tenant #2's skin. There were no further entries in the progress notes related to the open areas under an abdominal fold. A nurse review was not completed to monitor progress related to recommendations for treatment.	A 096		

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
	S0024	A. BUILDING _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 096	Continued From page 69 3. Tenant #9, a 90 year-old, was admitted on 6-24-13 and had diagnoses of: dementia and hypertension. On 2-25-15 Tenant #9 was staged at five on the GDS which indicated moderately severe cognitive decline. The nurse (health) evaluation completed 2-25-15 documented Tenant #9's skin condition was normal. The service plan of the same date documented the only treatment was support stockings. Progress notes dated 3-3-15 documented an order was received to cleanse a left hip wound thoroughly and to obtain a culture of the wound. Twice a day dressings were ordered. In an interview with the RN on 3-24-15 at 2:30 p.m. she stated Tenant #9 had hip surgery in November 2014, and Tenant #9 had developed a sore over the incision site that was infected. Once the infection cleared, a hole could be seen. Progress notes dated 3-20-15 documented Tenant #9 returned from the hospital following surgery to repair a dehiscence at the site of the previous hip surgery. A nurse review was not completed with a change of condition to assess and document the health status of the wound of Tenant #9 following the change in the hip incision site. 4. Tenant #11, an 87 year-old, was admitted on 8-18-14 and had diagnoses of: chronic inflammatory demyelinating polyneuropathy, benign prostatic hypertrophy, and atrial fibrillation. On 12-12-14 Tenant #11 was staged at one on the GDS which indicated no cognitive decline. Progress notes dated 3-2-15 documented Tenant #11 was sent to the hospital for a decline in	A 096		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 096	Continued From page 70 condition and did not return to the Program. On 12-4-14, Tenant #11 was admitted to the hospital for acute pharyngitis. According to the documentation from the hospital, Tenant #11 had several days of sore throat and increasing difficulty swallowing with a history of vomiting. Tenant #11 arrived at the hospital via ambulance. The hospital documentation documented Tenant #11 had a sore throat secondary to severe pharyngitis with impending airway obstruction. Tenant #11 was admitted to the intensive care unit. Tenant #11 also was diagnosed with pneumonia. A review of the clinical record revealed no evaluations completed after 9-10-14 until return from hospitalization on 12-12-14. There were no progress notes after 11-21-14 until return from hospitalization on 12-12-14. The clinical record lacked any documentation of Tenant #11's condition that led to hospitalization. Tenant #11 experienced a change of condition that warranted transport to the hospital via ambulance. Tenant #11 was admitted with severe pharyngitis with impending airway obstruction. Nurse reviews to assess and document the health status of Tenant #11 were not completed with a changing condition. Progress notes dated 12-18-14 documented Tenant #11 went to the hospital by ambulance and returned the same day with an order for a hospital bed and an antibiotic for 10 days. A nurse review was not completed when the antibiotics were finished to monitor progress related to the antibiotic.	A 096		

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
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A 096	Continued From page 71 A progress note from the physician dated 12-22-14 documented Tenant #11 was seen in the emergency room on 12-18-14 and diagnosed with acute bronchitis. The physician documented Tenant #11 struggled chronically with breathing when lying flat on the back. A hospital bed was ordered to keep the head of the bed elevated secondary to gastroesophageal reflux disease. The physician documented Tenant #11 did no move independently and required transfers. Tenant #11 was noted to be at risk for skin breakdown. The physician documented Tenant #11 required a hospital bed as a medical necessity to assist Tenant #11 with breathing, swallowing, and ridding self of respiratory secretions. An air mattress was recommended to prevent skin breakdown. The RN noted the documentation on 1-13-15. A nurse review was not completed to assess and document the health status of Tenant #11 with a change of condition. 5. Tenant #12, a 90 year-old, was admitted on 10-9-10 and had diagnoses of: gastroesophageal reflux disease, diabetes, hypertension, osteoarthritis, hypertensive encephalopathy, and dementia. On 12-4-14 Tenant #12 was staged at three on the GDS which indicated mild cognitive decline. The service (functional) evaluation dated 12-4-14 documented Tenant #12 required escorts to and from activities and meals. The evaluation revealed a gait belt was to be used for all transfers and a slide board was available as needed. The service plan of 12-4-14 reflected the functional evaluation. The nurse (health) evaluation of 12-4-14	A 096		

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 096	Continued From page 72 documented Tenant #12 had severely limited range of motion to both upper and lower extremities. Tenant #12 had poor posture, poor coordination, and poor balance. Tenant #12 was unable to bear weight. Progress notes dated 12-16-14 and timed 2:17 p.m. documented Tenant #12 would be receiving "pre-hospice" care from a nurse practitioner. Progress notes dated 12-22-14 and 1-5 and 1-12-15 documented Tenant #12 slid out of a lift chair. Progress notes dated 1-17-15 and timed 4:55 a.m. documented Tenant #12 had expired. Staff B was interviewed on 3-24-15 at 1:10 p.m. and stated Tenant #12 always took two to transfer for "quite a long time, several weeks." Tenant #12 was incontinent and was usually wet. Tenant #12 was bedbound the last week of life. Staff C was interviewed on 3-25-15 at 9:41 a.m. and stated Tenant #12 was a two-person assist since last fall. Staff D was interviewed on 3-25-15 at 10:19 a.m. and stated Tenant #12 started sleeping all the time and was bedbound the last month of life. Staff E was interviewed on 3-24-15 at 2:19 p.m. and stated Tenant #12 required two persons for transfer for weeks or months. Staff F was interviewed on 3-25-15 at 8:44 a.m. and stated Tenant #12 required two persons for transfer 100% of the time the last month of life. Tenant #12 was incontinent and sometimes needed assistance to eat.	A 096		

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
	S0024	A. BUILDING: _____ B. WING _____	C 03/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

(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 096	Continued From page 73 In an interview with the RN at exit, she stated Tenant #12 had declined just one or two days prior to death. The RN provided a delegation form for end of life care and stated she had prepared the information for staff use. The delegation form instructed every two hour checks for mouth care, perineal care, and repositioning. A nurse review was not completed after 12-4-15 to assess and document the health status of Tenant #12 who required end of life care with a change of condition.	A 096		

Plan of Correction
Ames Bickford

A. (A 004) Program policies and procedures
Regulatory Insufficiency: Based on observation and a review of policies, the Program's policies were not followed.

Plan of Correction:
The insufficiency will be corrected as follows:
- Bickford Staff will follow the handwashing policy, including during medication administration.
- Mandatory staff meeting will be held on 04/24/15 to provide re-education on policies of hand washing and glove utilization.

The following measures will be taken to ensure the problem does not recur:
- RNC will monitor med passes weekly to ensure policies and procedures are being followed.
- RNC received further training on 04/07/15, 04/09/15, and 04/10/15 by Divisional Director of Resident Services.

The program will monitor performance to ensure compliance as follows:
- Divisional Director of Resident Services will monitor med pass at least twice a year to ensure compliance with universal precautions during med administration.

Date deficiencies corrected by: 04/24/15

B. (A 036) Medications
Regulatory Insufficiency: Based on observation, medication orders, and interview, medications were not administered correctly.

Plan of Correction:
The insufficiency will be corrected as follows:
- RNC will ensure all staff are sufficiently trained and competent in tasks as assigned, utilizing nurse delegation as appropriate.
- The RNC provided additional training on medication administration with Staff B on 04/13/15.

The following measures will be taken to ensure the problem does not reoccur:
- RNC will monitor med passes weekly to ensure that policies and standard medication practices are met, including those for insulin administration.
- The RNC received further training on 04/07/15, 04/09/15, and 04/10/15 by Divisional Director of Resident Services.

The Program will monitor performance to ensure compliance as follows:

- Divisional Director of Resident Services will monitor med pass at least twice a year during core checks to ensure compliance.

Date deficiencies corrected by: 04/13/15

C. (A 064) Staffing

Regulatory Insufficiency: **The Program failed to have in place a system for staff members to communicate tenant occurrences in writing and failed to keep written staff communication for three years.**

Plan of Correction:

The insufficiency will be corrected as follows:

- All staff meeting will be held on 04/24/15 to provide retraining on polices for proper documentation, utilizing the Progress Notes in the resident's chart.
- All staff will complete online Redi-learning program for documentation by 05/01/15.
- The RNC will ensure that all staff are sufficiently trained in proper documentation, according to policy, to communicate changes with residents' health, functional, and cognitive status.

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

- All new hires will complete nurse delegation and documentation training during onboarding process, prior to working on the floor and as appropriate on an on-going basis.
- The RNC received further training on 04/07/15, 04/09/15, and 04/10/15 including the use of Progress Notes in the resident's chart for staff documentation and RNC follow-up.

The Program will monitor performance to ensure compliance as follows:

- Divisional Director of Resident Services will review nurse delegations and resident chart documentation at least twice a year during core checks to ensure compliance.

Date deficiencies corrected by: 05/01/15.

D. (A 121) Record Checks

Regulatory Insufficiency: **The Program failed to request an evaluation from the department of human services.**

Plan of Correction:

The insufficiency will be corrected as follows:

- The Director will complete criminal, dependent adult abuse, and child abuse record checks prior to hire and obtain further evaluations as needed, according to state regulation and policy.
- Evaluation sent to Department of Human Services for Staff F on 4/16/15.

- Staff F suspended until found to be eligible for hire by the Department.

The following measures will be taken to ensure the problem does not reoccur:
- The Director will follow pre-hire checklist to ensure all checks are completed and information is obtained.

The Program will monitor performance to ensure compliance as follows:
- Divisional Director of Operations to review personnel files at least twice a year to monitor compliance.

Date deficiencies corrected by: 5/1/15.

E. (A 037) Evaluation of Tenant
Regulatory Insufficiency: Evaluations of function, cognition, and health were not completed with changes of condition to determine continued eligibility for the program and to determine any changes to services needed.

Plan of Correction:
The insufficiency will be corrected as follows:
- RNC will ensure assessments of health, cognition, and function are completed with any significant changes in health status to ensure resident remains appropriate for assisted living level of care and changes to services are identified for updating of the resident's Service Plan.
- Resident #8 health, cognitive, and functional evaluations were completed on 04/09/15 and reflect his current identified needs.
- Resident #10 health, cognitive, and functional evaluations were completed on 04/09/15 and reflect her current identified needs.
- Resident #11 discharged from the branch on 03/02/15.
- Resident #12 passed away at the branch on 01/17/15.

The following measures will be taken to ensure the problem does not reoccur:
- The RNC received additional training on 04/07/15, 04/09/15, and 04/10/15 by Divisional Director of Resident Services on the need to complete evaluations with significant changes in the resident's condition.

The Program will monitor performance to ensure compliance as follows:
- Divisional Director of Resident Services will complete core checks on evaluations at least twice a year to ensure compliance.

Date deficiencies corrected by: 04/09/15

F. (A 039) Criteria for Admission/Retention of Tenants
Regulatory Insufficiency: Two tenants required routine two-person assist with transfer and exceeded criteria for retention.

Plan of Correction:
The insufficiency will be corrected as follows:
- RNC will ensure assessments of health, cognition, and function are completed with any significant changes in health status to ensure resident remains appropriate for assisted living level of care and changes to services are identified.
- Resident #8 requires routine two-person assistance for safe transfer and a 30 day notice of discharge will be given to resident and family on 04/14/15.
- Resident #10 requires routine two-person assistance for safe transfer and a 30 day notice of discharge will be given to resident and family on 04/14/15.

The following measures will be taken to ensure the problem does not reoccur:
- The RNC received additional training on 04/07/15, 04/09/15, and 04/10/15 by Divisional Director of Resident Services on regulations related to admission and retention of residents.

The Program will monitor performance to ensure compliance as follows:
- Divisional Director of Resident Services will complete core checks of evaluations and resident services at least twice a year to ensure residents remain appropriate for assisted living.

Date deficiencies corrected by: 04/15/15 (plus 30 days maximum)

G. (A 083) Service Plans
Regulatory Insufficiency: Service plans were not based on evaluations, and did not meet the specific service needs of individual tenants. Service plans were not updated when changes were needed.

Plan of Correction:
The insufficiency will be corrected as follows:
- RNC will ensure Service Plans reflect the resident's needs and preferences, as assessed.
- Resident #2 Service Plan was updated on 03/26/15 and reflects current identified needs and preferences.
- Resident #8 Service Plan was updated on 04/09/15 and reflects current identified needs and preferences.
- Resident #9 Service Plan was updated on 04/05/15 and reflects current identified needs and preferences.
- Resident #10 Service Plan was updated on 04/09/15 and reflects current identified needs and preferences.
- Resident #11 discharged from the branch on 03/02/15.
- Resident #12 passed away at the branch on 01/17/15.

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

- The RNC received additional training on 04/07/15, 04/09/15, and 04/10/15 by Divisional Director of Resident Services on development of individualized Service Plans to meet the resident's current needs and preferences.

The Program will monitor performance to ensure compliance as follows:

- Divisional Director of Resident Services will complete core checks of Service Plans at least twice a year to ensure they reflect the resident's current assessed needs.

Date deficiencies corrected by: April 9, 2015.

H. (A 084) Service Plans

Regulatory Insufficiency: Service plans were not developed in consultation with the tenant prior to the signing of the occupancy agreement.

Plan of Correction:

The insufficiency will be corrected as follows:

- RNC and Director will ensure that evaluations are completed and a preliminary Service Plan is developed prior to signing of the occupancy agreement.

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

- The RNC and Director received additional training on 03/30/15, 04/07/15, 04/09/15, and 04/10/15 regarding the necessity for evaluations and Service Plan development prior to signing the Admission Agreement.

The Program will monitor performance to ensure compliance as follows:

- Divisional Director of Operations will complete core checks of Admission Agreements at least twice a year to ensure compliance with regulation.

Date deficiencies corrected by: 03/30/15.

I. (A 096) Nurse Review

Regulatory Insufficiency: Nurse Rrviews were not completed to assess and document the health status of each tenant and to monitor progress related to previous recommendations every 90 days and with changes of condition.

Plan of Correction:

The insufficiency will be corrected as follows:

- RNC will ensure Nurse Reviews are completed every 90 days and with any changes in condition that meet regulatory compliance.
- Resident #8 had a Nurse Review update on 04/09/15 that meets regulatory expectations is reflected in that review.

- Resident #2 had a Nurse Review update on 03/26/15 that meets regulatory expectations is reflected in that review.
- Resident #9 had a Nurse Review update on 04/05/15 that meets regulatory expectations is reflected in that review.
- Resident #11 discharged from the branch on 03/02/15.
- Resident #12 passed away at the branch on 01/17/15.

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

- The RNC received additional training on 04/07/15, 04/09/15, and 04/10/15 by Divisional Director of Resident Services on documentation of regulatory-compliant Nurse Reviews.

The Program will monitor performance to ensure compliance as follows:

- Divisional Director of Resident Services will complete core checks of Nurse Reviews at least twice a year to ensure compliance.

Date deficiencies corrected by: April 9, 2015.