IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
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KIM REYNOLDS
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RODNEY A. ROBERTS, DIRECTOR

April 15, 2015

Ms. Kris Trotter, Director
Bickford Cottage Cedar Falls
5101 University
Cedar Falls, IA 50613-6246

RE: Final Recertification Monitoring Evaluation Report – Bickford Cottage Cedar Falls, Cedar Falls, IA

Dear Ms. Trotter:

Enclosed is the **Final Recertification Monitoring Evaluation 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 a survey by DIA on **April 7, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Record checks and Dementia Specific Education for Program Personnel.

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.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Also enclosed you will find the Assisted Living Program Certificate **S0028** with effective dates of **February 1, 2015** through **January 31, 2017**.

If you have any questions in regard to this 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
	S0028	A. BUILDING: _____ B. WING _____	04/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	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: 37 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 41 TOTAL census of Assisted Living Program: The following regulatory insufficiencies were cited during the Recertification conducted to determine compliance with certification for an Assisted Living Program.	A 000		
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:	A 121		

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A 121	Continued From page 1 Based on review of staff files, two staff were employed prior to completion of the evaluation to determine whether the criminal background checks warrant prohibition of the person's employment in the program. Per review of five staff files, two staff had criminal, dependent adult and child abuse record checks completed. Staff A's file indicated a possible criminal record and Staff B's file indicated further research was required. The Program did not complete the evaluations required to determine the person's employment in the Program. Staff A, a CNA, was hired on 9-5-12. Criminal, dependent adult and child abuse record checks were completed on 12-12-13 after the Department identified criminal, dependent adult and child abuse checks had not been completed. The results of the criminal check indicated a possible criminal history. The Program did not complete the evaluation required to determine the person's employment in the Program. Staff B, a Kitchen staff, was hired on 7-16-12. Criminal, dependent adult and child abuse record checks were completed on 6-27-12. The results of the criminal check indicated further research was required. The Program was to await DCI's final response for criminal history before employing Staff B. The Program did not have documentation of the DCI final response.	A 121		
A 123	481-69.30(3) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel.	A 123		

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A 123	Continued From page 2 69.30(3) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually. Direct-contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on review of staff files, direct care staff employed by the dementia-specific Program did not receive a minimum of eight hours of dementia-specific continuing education annually. Per review of five staff files, Staff A, C and D, direct care staff, did not receive a minimum of eight hours of dementia-specific continuing education annually. Staff A's file was reviewed. Staff A, a CNA, received 2.5 hours of dementia specific continuing education on 1-30-14 and 5.0 hours of dementia specific continuing education hours on 1-31-14 for a total of 7.5 hours. Staff A did not receive a minimum of eight hours of dementia specific continuing education annually. Staff C's file was reviewed. Staff C, a CNA, received 7.5 hours of dementia specific continuing education on 10-30-14. Staff C did not receive a minimum of eight hours of dementia specific continuing education annually. Staff D's file was reviewed. Staff D, a CMA, received 3.5 hours of dementia specific continuing education on 1-24-14 and 4.0 hours of dementia specific continuing education on	A 123		

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A 123	Continued From page 3 1-26-14 for a total of 7.5 hours. Staff D did not receive a minimum of eight hours of dementia specific continuing education annually.	A 123		

April 27, 2015

Rose Boccella, Program Coordinator
Adult Services Bureau
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

Dear Ms Boccella:

This letter is in response to the Final Recertification Monitoring Evaluation Report conducted at the Cedar Falls Bickford on April 7th, 2015.

The following document will serve as the written Plan of Correction addressing the regulatory insufficiencies identified during the visit.

If you have additional questions and/or concerns, please contact me at 319-266-6800 or kris.trotter@enrichinghappiness.com

Sincerely,

Kris Trotter

Kris Trotter, Director
Cedar Falls Bickford

Plan of Correction
Cedar Falls Bickford

A. (A121) Record Checks

Regulatory Insufficiency: The Program did not complete the evaluations required to determine the person's employment in the Program.

Plan of Correction
The insufficiency will be corrected as follows:
- The Program will complete the necessary background checks and receive approval that the staff member is eligible for hire, prior to hire.
- Staff A was suspended on 4/10/15 until the background check is completed and employee is determined eligible to work in the Program. All necessary paperwork has been submitted by the employee and the Program, with results expected within the next 5 days.
- The Program received DCI final clearance on Staff B on 4/10/15. The documentation of this has been placed in the employee file.

The following measures will be taken to ensure the problem does not reoccur:
- The Director was re-educated on the necessary steps to be taken with pre-hire background checks on April 7, 2015.
- The Director will follow the 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 will review personnel files at least twice a year to monitor compliance.

Date deficiencies corrected by: 04/30/15

B. (A123) Dementia Specific Education for Personnel

Regulatory Insufficiency: Direct care staff did not receive a minimum of eight hours of dementia-specific continuing education annually.

Plan of Correction:
The insufficiency will be corrected as follows:
- All direct care staff will complete at least eight hours of dementia-specific training annually.
- Staff A, who is currently suspended, will complete the required number of dementia-specific continuing education hours upon clearance to return to work. These training hours will be completed by April 30, 2015.

- Staff C and D will complete the required number of dementia-specific continuing education hours by April 30, 2015.

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

- The Director was re-educated on the necessity to ensure all direct care staff receive the required dementia-specific education on an annual basis on April 7, 2015.
- A new-hire checklist will be followed while creating personnel files to avoid this oversight on new hires. A checklist system will be maintained to monitor the required dementia training for all staff upon hire and yearly thereafter.

The Program will monitor performance to ensure compliance as follows:

- Director of Operations will review personnel files at least twice a year to monitor compliance.

Date deficiencies corrected by: 4/30/15