IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
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KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

December 22, 2015

Complaint Intake #: 56442-C

Ms. Tracy Keely, Director
Bickford Cottage Marion
1100 Linden Drive
Marion, IA 52302

RE: Final Complaint Investigation & Recertification Monitoring Evaluation Report – Bickford Cottage Marion, Marion, IA

Dear Ms. Keely:

Enclosed is the **Final Complaint Investigation & 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 **December 10 - 15, 2015.** Based on review of tenant files, review of incident reports, review of policies and procedures, review of bathing schedules, review of housekeeping schedules, interviews with staff, interview with the Director and monitor observations, the following was found:

Allegation: Service Plans
Findings: Not substantiated
Comments: Review of tenant files and policies and procedures indicated the Program individualized tenant plans to identify their identified needs. Bath schedules were reviewed and indicated all tenants were offered and provided bathing services per tenant and/or family preference as outlined in the tenant's service plan. Housekeeping schedules were reviewed and indicated tenant apartments were cleaned at least weekly and as frequently as three times per week as identified needs indicated. Per an interview with the Director, the housekeeper provided deep cleaning; scrubbed the bathroom floors and vacuumed the carpet and the caregivers performed daily checks and light housekeeping. No concerns with service plans were identified.

The Report notes Regulatory Insufficiencies in the area(s) of: Dependent Adult Abuse Training, Food Service and Dementia Specific Education for 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 or a contested case hearing 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.

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
	S0029	A. BUILDING: _____ B. WING _____	C 12/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE MARION	1100 LINDEN DR MARION, IA 52302

(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 Definition Number of tenants without cognitive disorder: 18 Number of tenants with cognitive disorder: 6 Total Population of Program at time of on-site: 24 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 7 Total Population of Program at time of on-site: 7 TOTAL census of Assisted Living Program: 31 No regulatory insufficiencies were cited during the investigation of Complaint #56442-C. The following regulatory insufficiencies were cited during the Recertification conducted to determine compliance with certification for an Assisted Living Program. Iowa Code 235B.16(5)(b) A person required to report cases of dependent adult abuse pursuant to sections 235B.3 and 235E.2, other than a physician whose professional practice does not regularly involve providing primary health care to adults, shall complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment or self-employment which involves the examination, attending, counseling, or treatment of adults on a regular basis. Within one month of	A 000		

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A 000	Continued From page 1 initial employment or self-employment, the person shall obtain a statement of the abuse reporting requirements from the person's employer or; if self-employed, from the department. The person shall complete at least two hours of additional dependent adult abuse identification and reporting training every five years. This RULE is not met as evidenced by: Based on review of staff files, staff had not received two hours of training related to the identification and reporting of dependent adult abuse training within six months of initial employment. 1. Six staff files (Staffs A, B, C, D, E and F) were reviewed. Training related to the identification and reporting of dependent adult abuse within six months of initial employment was not available for Staffs A, B, and C. Staff A was hired on 4-9-12; Staff B was hired on 12-17-12 and Staff C was hired on 2-14-12. Review of staff files for Staffs A, B and C did not include any evidence of Dependant Adult Abuse (DAA) training. 2. On 12-14-15, the Director stated she spoke with Staff A, B and C and they thought they had completed DAA training but did not have a certificate or any documentation to provide. The Director contacted a former employee who stated she had trained the staff but was not able to provide any documentation of DAA training. 3. Staff files for Staffs A, B and C did not reflect at least two hours of DAA training within six months of initial employment.	A 000		
A 104	481-69.28(5) Food Service	A 104		

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A 104	Continued From page 2 481-69.28(231C) Food service. 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on review of staff files and a Director interview, an orientation on sanitation and safe food handling prior to handling food and an annual in-service training on food protection was not provided. 1. Review of six staff files (Staff A, B, C, D, E and F) indicated Staff D was hired on 7-21-15 and had not received an orientation on sanitation and safe food handling prior to handling food. Review of Staff F's file indicated Staff F was hired on 3-31-14. Staff F had an orientation on sanitation and safe food handling on 4-12-14. Staff F did not have an annual in-service training on food protection. 2. On 12-15-15, the Director was interviewed and stated there was no evidence of food training for Staff D and F.	A 104		
A 121	481-69.30(1) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(1) All personnel employed by or	A 121		

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A 121	Continued From page 3 contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on review of staff files and a Director interview, personnel employed did not receive a minimum of eight hours of dementia specific education and training within 30 days of employment. 1. Review of six staff files (Staff A, B, C, D, E and F) indicated Staff D and E did not have any dementia specific education and training within 30 days of employment. Staff D was hired on 7-21-15 and Staff E was hired on 9-8-15. 2. On 12-15-15, the Director was interviewed and stated Staff D and E did not have any dementia specific training. She stated she thought they had six months to complete the training.	A 121		
A 123	481-69.30(3) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 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.	A 123		

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A 123	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of staff files and a Director interview, staff did not receive a minimum of eight hours of dementia-specific continuing education annually. 1. Review of six staff files (Staff A, B, C, D, E and F) indicated Staffs A, B, C and F did not receive a minimum of eight hours of dementia-specific education annually. 2. Staff A's file reflected certificates for web based training on 12-28-13 for 2.5 hours and on 12-29-13 for 4 hours. The training totaled 6.5 hours. Staff A did not have any training in 2014 or 2015. Staff A did not have a minimum of eight hours of dementia-specific continuing education annually. Staff B's file reflected certificates for web based training on 12-30-14 for 2.5 hours, 12-31-14 for 3.5 hours and on 1-3-15 for 1.5 hours of dementia specific training. The training totaled 7.5 hours. Staff B did not have a minimum of eight hours of dementia-specific continuing education annually. Staff C's file reflected certificates for web based training on 12-11-15 for 4 hours and on 12-12-15 for 3 hours. The training totaled 7 hours. Staff C did not have a minimum of eight hours of dementia-specific continuing education annually. Staff F's file reflected certificates for web based training on 3-31-14, 4-1-14 and 4-2-14. The certificates did not indicate the length of the	A 123		

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A 123	Continued From page 5 courses. Staff F did not have any training during 2015. Staff F did not have a minimum of eight hours of dementia-specific continuing education annually. 3. On 12-15-15, the Director was interviewed and stated she could not find any other dementia-specific training for Staff A, B, C and F.	A 123		

Plan of Correction
Marion Bickford Cottage

A. Dependent Adult Abuse
Regulatory Insufficiency: Staff had not received two hours of training related to the identification and reporting of dependent adult abuse within six months of initial employment.

Plan of Correction:
The insufficiency will be corrected as follows:
- The Director will ensure that all staff receives Dependent Adult Abuse training upon hire and on-going training will be completed every 5 years thereafter.
- Documentation of the training will be maintained as part of their personnel file.

The following measures will be taken to ensure the problem does not recur:
- The Director and RNC were re-educated on the expectation of having every employee complete this training, per State regulations.
- All staff were educated by the Director and RNC that they will need to maintain this certification every 5 years.

The program will monitor performance to ensure compliance as follows:
- The Divisional Director of Operations will audit employee files, at least twice a year, for appropriate training documentation.

The date by which the regulatory insufficiency will be corrected:
- The Dependent Adult Abuse training will be complete on or before January 22, 2016.

B. Food Service
Regulatory Insufficiency: An orientation on sanitation and safe food handling prior to handling food and an annual in-service training on food protection was not provided.

Plan of Correction:
The insufficiency will be corrected as follows:
- The Director will ensure new staff are trained upon hire and annually thereafter by the Kitchen Manager in sanitation, safe food handling and food protection.
- Documentation of all training will be kept in the staff personnel files.

The following measures will be taken to ensure the problem does not recur:
- The Director was re-educated on the need to provide training on food service upon hire and annually to meet the State's expectations.

The program will monitor performance to ensure compliance as follows:
- The Divisional Director of Operations will audit the staff personnel files once a year to ensure compliance.

The date by which the regulatory insufficiency will be corrected:
- All Food Service training will be completed on or before January 22, 2016.

Regulatory Insufficiency: Personnel employed did not receive a minimum of eight hours of dementia specific education and training within 30 days of employment.

C. Dementia Specific Education for Personnel

Regulatory Insufficiency: Personnel employed did not receive a minimum of eight hours of dementia specific education and training within 30 days of employment.

Plan of Correction:

The insufficiency will be corrected as follows:

- The Director will ensure that all employees complete dementia training upon hire and annually to meet State regulations.

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

- The Director was re-educated on the need for all employee to receive the necessary education and training to care for dementia-specific residents upon hire and annually to meet the requirements.

The program will monitor performance to ensure compliance as follows:

- The Divisional Director of Operations will audit the personnel files to ensure that appropriate training is occurring and being documented, at least annually.

The date by which the regulatory insufficiency will be corrected:

- All dementia training will be completed on or before January 22, 2016.