

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/04/2017
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NAME OF PROVIDER OR SUPPLIER BICKFORD COTTAGE CEDAR FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 5101 UNIVERSITY CEDAR FALLS, IA 50613
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(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 Dementia-Specific Program by Definition Number of tenants without cognitive disorder: 20 Number of tenants with cognitive disorder: 16 Total Population of Program at time of on-site: 36 No regulatory insufficiencies were cited during the investigation of Complaint # 71050-C and Incident # 69214-I.	A 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

TITLE

(X6) DATE