1/19/18 OK 1/19/18

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
	S0012	A. BUILDING: _____ B. WING _____	C 12/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE MARSHALLTOWN	101 NEW CASTLE RD MARSHALLTOWN, IA 50158

(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	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: 31 Number of tenants with cognitive disorder: 9 Total Population of Program at time of on-site: 40 TOTAL census of Assisted Living Program: 40 No regulatory insufficiencies were cited during the Investigation of Incident #72530-I. The following regulatory insufficiencies were cited during the Investigation of Incident #72530-I.	A 000	See attached POC 12/19/17	
A 012	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff consistently treated tenants with consideration, respect, and full recognition of personal dignity and autonomy. This pertained to 1 out of 1 tenant reviewed during the investigation of incident #72530-I (Tenant #1). Findings follow: Record review revealed an incident report, dated 11-12-17, documented a verbal altercation	A 012		

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A 012	Continued From page 1 occurred between a tenant and a staff. The tenant and staff yelled at each other. An investigation form, dated 11-12-17, documented a verbal altercation occurred between a resident and a staff member. The Program suspended Staff A immediately pending the outcome of the investigation. Continued record review revealed Tenant #1's Service Plan, dated 10-24-17 revealed he/she became confused at times due to lack of blood flow to the brain from his/her heart condition. He/she could become irrational and yell at staff when things did not go his/her way. Staff should speak calmly to him/her and reassure him/her they would work it out. Additional record review revealed Staff A completed the following trainings: a. 6-10-16: Orientation which included Resident Bill of Rights b. 1-3-17: Iowa Abuse of Dependent Adults c. 5-10-17: In-Service Course Attendance Sheet for Resident Abuse and Reporting Record review revealed Bickford Senior Living Resident Bill of Rights, revised 1-2014. According to the document, "... All residents have the right to be treated with consideration, respect, and full recognition of personal dignity and autonomy..." During and interview on 12-18-17 at 8:53 a.m. Tenant #1 stated Staff A yelled at her and used an expletive term. Tenant #1 stated she was afraid of Staff A and it was not very nice of Staff A to talk to someone the way. When interviewed on 11-30-17 at 8:48 a.m. Staff A stated she worked 11-11-17 and 11-12-17. She	A 012		

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A 012	Continued From page 2 confirmed she engaged in a verbal argument with Tenant #1 on both days. She admitted to using profanity on both days, pointing her finger in Tenant #1's face, and calling him/her an expletive term. Staff A admitted she became frustrated with Tenant #1 due to the amount of help he/she requested when he/she was capable of doing for himself/herself. Staff A admitted her behavior was wrong and this was not how she was trained to respond. She confirmed she should not have engaged in a verbal argument or used profanity directed at Tenant #1. She admitted she did not follow his/her Service Plan and did not talk calmly to him/her. She stated she should have walked away and/or asked for assistance from another staff as she was trained. During an interview on 11-29-17 at 4:24 p.m. Staff B stated she worked November 11 and 12, 2017. Staff B confirmed she heard Staff A call Tenant #1 an expletive term and Staff A used other profanity directed at the tenant. She stated she notified the Director of the incident on 11-12-17. During an interview on 11-30-17 at 10:03 a.m. the Director stated on 11-13-17, Staff A admitted she used profanity and called Tenant #1 an expletive term. The Director stated all staff were retrained on resident abuse and reporting on 5-10-17, which included verbal abuse. She stated she expected staff to walk away from a situation that could escalate and it would not be acceptable to engage in a verbal argument and/or use profanity directed toward a tenant.	A 012		

Bickford

1/9/18 OK 1/9/18

Plan of Correction
Marshalltown Bickford Cottage

A012

Regulatory Insufficiency: Tenant Rights. The Program failed to ensure staff consistently treated tenants with dignity, respect and full recognition of personal dignity and autonomy.

Plan of Correction:

The insufficiency will be corrected as follows:

- Staff A's employment with Bickford of Marshalltown was terminated.

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

- The Director will ensure all staff receive mandatory, ongoing training on Resident Rights.

The program will monitor performance to ensure compliance as follows:

- All employees were required to attend a mandatory in-service on Resident Rights on 12/19/17.
- Divisionals will review documentation at least annually to ensure that appropriate in-service on Resident Rights is occurring.

Date deficiencies corrected by: 12/19/2017.