STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP019	A. BUILDING _____ B. WING _____	09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE FORT DODGE	1536 20TH AVENUE N FORT DODGE, IA 50501

(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: 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 The following regulatory insufficiencies were cited during the investigation of Incident #107408-I . There were no regulatory insufficiencies cited during the investigation of Complaints #102970-C and #102219-C.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This Requirement is not met as evidenced by: Based on record review and staff interview, the Program failed to ensure tenants received adequate and appropriate treatment and services. This affected 4 of 5 sample tenants (Tenants #1, #3, #4, and #5). Findings include: Record review revealed an allegation of mistreatment reported to the Department on 9/01/22 concerning a staff person (Staff G) being inappropriate physically and verbally with the tenants of the Program that effected Tenants #1, #3, #4 and #5. The Program learned of the alleged mistreatment of the tenants following Staff M's and Staff N's report to the Administrator who in turn reported the allegations to the Department.	A 150		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 150	Continued From Page 1 Additional review revealed the allegations first surfaced at a Wednesday 8/31/22 staff meeting when Staff M insinuated a certain staff person was being rough with the tenants. Staff M did not disclose the person's name at the time. The Administrator began to question Staff M and others, including Staff H, to identify the staff person who was allegedly mistreating the tenants. The Administrator asked Staff M if she was talking about Staff G at the meetin, which she confirmed. The Administrator also called Staff H later the same evening to ask if she had ever seen a staff physically abuse or get rough with a resident at the program. Staff H said to the Administrator, "No." Staff M said the next day after Staff G was suspended, Staff H and Staff M talked in the laundry room. Staff H then felt she should come forward and did so on 9/01/22. Staff G who denied any wrongdoing was suspended on 8/31/22. Staff M was asked by the Administrator on 9/01/22 to provide a written statement. Staff M reported Staff G had redirected Tenant #5 back to the Tenant's room in a forceful manner shoving her in the middle of her back while doing so. This incident was noted to have occurred on Sunday August 28th, 2022 but not reported until 9/01/22. It had not been immediately reported to a supervisor or documented as an incident. On 9/01/22 Staff N came forward and wrote two separate statements regarding Staff M, Staff N and Staff G. The first incident involved Staff M, Staff N and Staff G when Staff G had used a restraint to restrain Tenant #3's arms when taking her pills. The date and time when this was said to have occurred was unknown. Staff reported they thought this would have occurred back in May 2022. While attempting to investigate the alleged report, staff were also inconsistent with the time the incident would have occurred. Staff M	A 150		

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A 150	Continued From Page 2 thought around 8:00p.m.. Staff N thought before supper. Residents eat at 5:00p.m.. The incident had not been documented in the progress notes or on an incident report form. Staff G denied any involvement. The second incident involved Staff H and Staff G while in the shower when Staff G temporarily restrained Tenant #3's arms when combative. The date and time of this incident was also unknown as it had not been documented in the progress notes or on an incident report form and it had not been immediately reported to a supervisor. Staff thought this incident had also occurred back in the month of May but was unsure. Staff G denied the use of a restraint. Staff interviews with Staff N and Staff M revealed both thought the incidents would have occurred in the month of May 2022. The Administrator had not been made aware of the incidents until September 01, 2022. On 9/07/22 Staff M had provided a second statement to the Administrator that noted the following: Staff M reported Staff G sprayed Tenant #4 in the face during a shower. The date and time was unknown. The incident had not been reported to a superior or documented. A second incident reported by Staff M was when Tenant #1 grabbed Staff G's wrist and tried to bite her. Staff G used the palm of her hand to push the forehead of Tenant #1 back to look her in the eye and said, "Do not bite me." The date and time of this incident was unknown. This incident had not been reported to a superior or documented. Staff M reported Staff G sprayed Tenant #1 with water while in the shower when Tenant #1 was becoming upset and told her to "Stop it." The date and time was unknown. The incident had not	A 150		

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A 150	Continued From Page 3 been reported to a superior or documented. On 9/07/22 at 12:00p.m. review of the Abuse and Neglect policy and procedures revealed, any Bickford Family Member (Staff) who has reasonable cause to believe that a resident is being, or had been abused, neglected or exploited shall report the information immediately to the Branch Director or RN Coordinator. The incidents as reported by Staff M and Staff N had not been immediately reported. On 9/13/22 at 4:30p.m. the Administrator confirmed these findings.	A 150		
A 155	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 record review and staff interview, the Program failed to ensure tenants received adequate and appropriate treatment and services. This affected 4 of 5 sample tenants (Tenants #1, #3, #4, and #5). Findings include: Record review revealed an allegation of mistreatment reported to the Department on 9/01/22 concerning a staff person (Staff G) being inappropriate physically and verbally with the tenants of the Program that effected Tenants #1, #3, #4 and #5. The Program learned of the alleged mistreatment of the tenants following Staff M's and Staff N's report to the Administrator who	A 155		

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A 155	Continued From Page 4 in turn reported the allegations to the Department. Additional review revealed the allegations first surfaced at a Wednesday 8/31/22 staff meeting when Staff M insinuated a certain staff person was being rough with the tenants. Staff M did not disclose the person's name at the time. The Administrator began to question Staff M and others, including Staff H, to identify the staff person who was allegedly mistreating the tenants. The Administrator asked Staff M if she was talking about Staff G at the meetin, which she confirmed. The Administrator also called Staff H later the same evening to ask if she had ever seen a staff physically abuse or get rough with a resident at the program. Staff H said to the Administrator, "No." Staff M said the next day after Staff G was suspended, Staff H and Staff M talked in the laundry room. Staff H then felt she should come forward and did so on 9/01/22. Staff G who denied any wrongdoing was suspended on 8/31/22. Staff M was asked by the Administrator on 9/01/22 to provide a written statement. Staff M reported Staff G had redirected Tenant #5 back to the Tenant's room in a forceful manner shoving her in the middle of her back while doing so. This incident was noted to have occurred on Sunday August 28th, 2022 but not reported until 9/01/22. It had not been immediately reported to a supervisor or documented as an incident. On 9/01/22 Staff N came forward and wrote two separate statements regarding Staff M, Staff N and Staff G. The first incident involved Staff M, Staff N and Staff G when Staff G had used a restraint to restrain Tenant #3's arms when taking her pills. The date and time when this was said to have occurred was unknown. Staff reported they thought this would have occurred back in May 2022. While attempting to investigate the alleged report, staff were also inconsistent with the time	A 155		

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A 155	Continued From Page 5	A 155		

the incident would have occurred. Staff M thought around 8:00p.m.. Staff N thought before supper. Residents eat at 5:00p.m.. The incident had not been documented in the progress notes or on an incident report form. Staff G denied any involvement. The second incident involved Staff H and Staff G while in the shower when Staff G temporarily restrained Tenant #3's arms when combative. The date and time of this incident was also unknown as it had not been documented in the progress notes or on an incident report form and it had not been immediately reported to a supervisor. Staff thought this incident had also occurred back in the month of May but was unsure. Staff G denied the use of a restraint.

Staff interviews with Staff N and Staff M revealed both thought the incidents would have occurred in the month of May 2022. The Administrator had not been made aware of the incidents until September 01, 2022.

On 9/07/22 Staff M had provided a second statement to the Administrator that noted the following:

Staff M reported Staff G sprayed Tenant #4 in the face during a shower. The date and time was unknown. The incident had not been reported to a superior or documented. A second incident reported by Staff M was when Tenant #1 grabbed Staff G's wrist and tried to bite her. Staff G used the palm of her hand to push the forehead of Tenant #1 back to look her in the eye and said, "Do not bite me." The date and time of this incident was unknown. This incident had not been reported to a superior or documented.

Staff M reported Staff G sprayed Tenant #1 with water while in the shower when Tenant #1 was becoming upset and told her to "Stop it." The

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A 155	Continued From Page 6 date and time was unknown. On 9/07/22 at 9:51a.m review of the Resident Bill of Rights revealed all residents have the right to be treated with consideration, respect, and full recognition of personal dignity and autonomy. On 9/13/22 at 4:30p.m. the Administrator confirmed these findings.	A 155		