STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP243	A. BUILDING _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE BURLINGTON	3301 STERLING DR BURLINGTON, IA 52601

(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 for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. General Population Number of tenants without cognitive disorder: 37 Number of tenants with cognitive disorder: 1 Memory Care Unit (if applicable) Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 5 TOTAL Census of Assisted Living Program for People with Dementia : 45 No regulatory insufficiencies were cited during the investigation into Complaints #102752-C and Complaint #101471-C. The following regulatory insufficiency was cited during the investigation into Complaint #101470-C.	A 000		
A 325	481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This Requirement is not met as evidenced by: Based on interview and record review, the program failed to ensure a sufficient number of staff available on hand to meet the needs of 1 of 2 discharged tenants (Tenant C1). Findings follow: Tenant C1 had a service plan dated 9/20/21. According to her service plan, staff were to assist with changing her clothing and toileting frequently throughout the day and night. Extra assistance was required due to pain in Tenant C1's legs and	A 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 325	Continued From Page 1 stiffness in her arms and legs. Tenant C1 had task sheets for January, 2022, February, 2022 and March, 2022. The task sheet indicated staff were to assist Tenant C1 with toileting during the morning shift, evening shift and night shift. In January, staff did not provide the directed toileting assistance to Tenant C1 on 23 of the 93 scheduled shifts. In February, the staff did not provide toileting assistance to Tenant C1 on 46 of 84 shifts. In March, the staff did not provide Tenant C1 with toileting assistance on 30 of 48 opportunities. Tenant C1 passed away on 3/17/22. On 9/7/22 at 9:36 AM, Staff A reported Tenant C1 was hard to take to the toilet. She said there were times when staff could not provide incontinence care to Tenant C1 immediately due to having a hard time finding another staff member to help them. On 9/7/22 at 9:54 AM, Staff B stated it was hard for staff to assist Tenant C1 with incontinence cares as at the end of her stay at the program as she was getting to be a 2-person assist with toileting. It was hard to move Tenant C1 from her wheelchair to the toilet and then back to her chair without assistance. This was particularly difficult on the overnight shift when there were fewer staff available to assist with cares. On 9/8/22 at 10:10 PM, the Registered Nurse Coordinator confirmed staff did not meet the identified toileting needs of Tenant C1.	A 325		