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
	S0028	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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. Number of tenants without cognitive disorder: 34 Number of tenants with cognitive disorder: 7 TOTAL Census of Assisted Living Program for People with Dementia: 41 This Program has met criteria to be an Assisted Living Program for People with Dementia by definition for the last two recertification visits. The investigation of Incident #99477-I and the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program were completed. The following regulatory insufficiencies were identified: 231C.5 Written occupancy agreement required. 1. An assisted living program shall not operate in this state unless a written occupancy agreement, as prescribed in subsection 2, is executed between the assisted living program and each tenant or the tenant s legal representative, prior to the tenant's occupancy, and unless the assisted living program operates in accordance with the terms of the occupancy agreement. The assisted living program shall deliver to the tenant or the tenant s legal representative a complete copy of the occupancy agreement and all supporting documents and attachments and shall deliver, at least thirty days prior to any changes, a written copy of changes to the occupancy agreement if any changes to the copy originally	A 000	POC attached OK 4-22-22	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
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
	S0028	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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	Continued From page 1 delivered are subsequently made. This Requirement is not met as evidenced by: Based on interview and record review the Program failed to obtain occupancy agreements signed by the tenant or tenant's legal representative, prior taking occupancy. This pertained to 2 of 4 current tenants reviewed (Tenants #2 and #4). Findings follow: 1. Record review on 3-9-22 of Tenant #2's file revealed an admission date of 2-16-22. Tenant #2 moved in on 2-20-22. The Admission Agreement (occupancy agreement) indicated the rental agreement began on 2-20-22. The agreement was signed by Tenant #2's legal representative and the Director on 3-3-22, which was after Tenant #2's occupancy of the apartment. 2. Record review on 3-9-22 of Tenant #4's file revealed an admission date of 1-25-21. Tenant #4 moved in on 1-26-21. The Admission Agreement (occupancy agreement) indicated the rental agreement began on 1-31-21. The agreement was signed by Tenant #4's legal representative on 1-29-21 and a program representative on 1-31-21, which was after Tenant #4's occupancy of the apartment. 3. When interviewed on 3-9-22 at 2:01 p.m. the Nurse confirmed all of the occupancy agreements were provided for the tenants listed above.	A 000		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified	A 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0028	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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 345	Continued From page 2	A 345		

and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:

b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s).

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to complete nurse delegated training within 30 days of the employment. This pertained to 6 of 6 staff reviewed (Staff A, B, C, D, E and F). Findings follow:

1. Record review on 3-7-22 and 3-8-22 of Staff A's training documents revealed a hire date of 9-14-21. Nurse delegation documents were provided; however, the documents did not reflect a completion date for any of the the nurse delegated training provided to Staff A. The documentation provided did not indicate nurse delegation training occurred within 30 days of Staff A's hire date.

2. Record review on 3-7-22 and 3-8-22 of Staff B's training documents revealed a hire date of 8-2-21. Nurse delegation documents were provided; however, the documents did not reflect a completion date for any of the the nurse delegated training provided to Staff B. The documentation provided did not indicate nurse delegation training occurred within 30 days of Staff B's hire date.

Continued record review revealed Staff B administered medications and did not have nurse delegations completed at the time of the onsite for the administration of aerosolized medications,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0028	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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 345	Continued From page 3 eye drops or eye ointment. 3. Record review on 3-7-22 and 3-8-22 of Staff C's training documents revealed a hire date of 2-7-22. Nurse delegation documents were provided; however, the documents did not reflect a completion date for any of the the nurse delegated training provided to Staff C. The documentation provided did not indicate nurse delegation training occurred within 30 days of Staff C's hire date. 4. Record review on 3-7-22 and 3-8-22 of Staff D's training documents revealed a hire date of 7-19-22. Nurse delegation documents were provided; however, the documents did not reflect a completion date for any of the the nurse delegated training provided to Staff D. The documentation provided did not indicate nurse delegation training occurred within 30 days of Staff D's hire date. 5. Record review on 3-7-22 and 3-8-22 of Staff E's training documents revealed a hire date of 11-18-21. Nurse delegation documents were provided; however, the documents did not reflect a completion date for any of the the nurse delegated training provided to Staff E. The documentation provided did not indicate nurse delegation training occurred within 30 days of Staff E's hire date. 6. Record review on 3-7-22 and 3-8-22 of Staff F's training documents revealed a hire date of 11-15-21. Nurse delegation documents were provided; however, the documents did not reflect a completion date for any of the the nurse delegated training provided to Staff F. The documentation provided did not indicate nurse delegation training occurred within 30 days of	A 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0028	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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 345	Continued From page 4 Staff F's hire date. 7. When interviewed on 3-9-22 at 2:01 p.m. the Nurse indicated Staff B assisted with aerosolized medications, eye drops and eye ointment. She also said she typically completed nurse delegations after staff completed the initial hire paperwork with the Director. She developed a new sign off sheet that provided the completion date related to nurse delegated training.	A 345		
A 400	481-67.19(3) Record Checks 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a background check for staff prior to employment. This pertained to 1 of 6 staff reviewed (Staff D). Findings follow: 1. Record review on 3-7-22 and 3-8-22 of Staff D's training documents revealed a hire date of 7-19-21. A Single Contact License & Background Check document indicated an abuse registries background check and criminal history background check was completed on 3-7-22 at 4:33 p.m. The background check did not reveal any records found. 2. Continued record review revealed a timecard	A 400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0028	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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 400	Continued From page 5 record revealed Staff D first worked (training) on 7-19-21 at 8:30 a.m. 3. Further record review revealed Staff D's BFM Annual Training and Assignments Transcript indicated Staff D completed training on 7-19-21. 4. When interviewed on 3-8-22 at 2:49 p.m. the Director said when she pulled staff files for the onsite she noted the background check for Staff D was not there. She completed his background check and no results were found. Staff D worked full time.	A 400		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 3 of 4 current tenants reviewed (Tenants #2, #4 and #5) and 1 of 1 discharged tenant reviewed (Tenant C1). Findings follow: 1. Record review on 3-7-22 of Tenant C1's file revealed Progress Notes dated 8-12-21 indicated Tenant C1 would start cephalexin 500 milligram	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0028	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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 290	Continued From page 6	A 290		

(mg), twice daily, for five days, for a urinary tract infection (UTI).

Continued record review revealed a nurse's note was not documented when the antibiotic was completed and to monitor for any further signs or symptoms of a UTI. Nurse's notes were not documented by exception for Tenant C1.

2. Record review on 3-9-22 of Tenant #2's file revealed Unusual Occurrence Reports indicated the following:

-On 2-22-22 at 12:00 p.m. it was noted Tenant #2 was found on the floor by her bed.
-On 2-22-22 at 8:00 p.m. it was noted Tenant #2 was found on the floor next to her bed.
-On 2-24-22 at 1:00 a.m. it was noted Tenant #2 called for assistance, yelled as staff responded to her apartment and she was found on the floor.
-On 3-5-22 at 7:15 p.m. it was noted Tenant #2 was found on the floor in her apartment.
-On 3-6-22 at 8:45 a.m. it was noted Tenant #2 was found on the floor by her bed.
-On 3-6-22 at 4:15 p.m. it was noted Tenant #2 was found on the floor, Tenant #2 had attempted to self-transfer into bed.

Continued record review revealed a Physician Visits form dated 2-21-22 indicated an order was received for cefdinir 300 mg, twice daily, for 10 days, for an ear infection.

Further record review revealed a Progress Note dated 2-21-22 was completed when the order was received for cefdinir 300 mg, twice daily for 10 days. A nurse's note was not completed when the antibiotic was completed and to monitor for further signs or symptoms of the infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0028	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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 290	Continued From page 7 Continued record review revealed nurse's notes were also not completed related to the falls noted above. Nurse's notes were not documented by exception for Tenant #2. 3. Record review on 3-9-22 of Tenant #4's file revealed an Unusual Occurrence Report indicated on 1-24-22 at 4:35 p.m. Tenant #4 attempted to elope. Tenant #4 walked away and returned with a chair to "be used as a weapon." A nurse's note was not completed related to the incident on 1-24-22. Nurse's notes were not documented by exception for Tenant #4. 4. Record review on 3-9-22 of Tenant #5's file revealed Unusual Occurrence Reports indicated the following: -On 1-8-22 at 8:30 a.m. it was noted Tenant #5 had a fall with injury. Tenant #5 had a skin tear on his left arm. -On 2-11-22 at 7:30 p.m. it was noted staff followed Tenant #5 with a wheelchair down the hallway to his apartment. Tenant #5 refused to use the walker and wheelchair and he fell to his knees. -On 2-23-22 at 6:20 p.m. it was noted Tenant #5 was found on the floor in the laundry room. Continued record review revealed nurse's notes were not completed related to the falls noted above. Nurse's notes were not documented by exception for Tenant #5. 5. When interviewed on 3-9-22 at 2:01 p.m. the Nurse confirmed all nurse's notes (last three months) were provided.	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0028	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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 355	Continued From page 8	A 355		
A 355	481-69.26(2) Service Plans 69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to obtain a service plan signed by a tenant or tenant's legal representative prior to taking occupancy. This pertained to 1 of 1 tenant reviewed that was admitted since 1-1-22 (Tenant #2). Findings follow: 1. Record review on 3-9-22 of Tenant #2's file revealed an admission date of 2-16-22. Tenant #2 moved in to the Program on 2-20-22. A preliminary service plan was signed by the Nurse and Director dated 2-15-22. The service plan was signed by Tenant #2's legal representative dated 3-3-22 at 6:15 p.m. The service plan was not signed by Tenant #2 or her legal representative prior to taking occupancy. 2. When interviewed on 3-9-22 at 2:01 p.m. the Nurse said she completed Tenant #2's evaluations virtually as Tenant #2 lived out of the area. The date on the service plan was the soonest Tenant #2's legal representative could come in to sign the plan.	A 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0028	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to develop service plans that reflected the identified needs of the tenants. This pertained to 3 of 4 current tenants reviewed (Tenants #2, #4 and #5) and 1 of 1 discharged tenant reviewed (Tenant C1). Findings follow: 1. Record review on 3-7-22 of Tenant C1's file revealed Progress Notes dated 8-13-21 indicated physical therapy (PT)/occupational therapy (OT) was ordered for Tenant C1. Continued record review revealed the service plan dated 8-11-21 was not updated and did not reflect the PT/OT services. 2. Record review on 3-9-22 of Tenant #2's file revealed diagnoses included: hemiplegia and hemiparesis following a cerebral infarction (right dominant side affected) and vascular dementia without behavioral disturbance. When interviewed on 3-7-22 at 1:35 p.m. Staff G said Tenant #2 took two people to transfer the majority of the time. When interviewed on 3-8-22 at 10:39 a.m. Staff H said Tenant #2 sometimes took two people to	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0028	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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 395	Continued From page 10	A 395		

transfer. She said it depended on the person and time of day. Tenant #2 could transfer with one assist, a gait belt and bar.

Continued record review revealed the service plan updated on 3-7-22 for a change of condition reflected Tenant #2 was "up with one assist and a pivot with a gait belt for all transfers." Tenant #2 used a wheelchair. A "two assist may be used intermittently for safety." The service plan did not reflect the level of transfer assistance being provided for Tenant #2.

4. Record review on 3-9-22 of Tenant #4's file revealed a Physician's Order document indicated Tenant #4 had an order for Ensure High Protein supplement, drink one container, by mouth, daily. The order was dated 9-27-21.

Continued record review revealed the service plan dated 3-1-22 did not reflect the supplement provided daily.

5. Record review on 3-9-22 of Tenant #5's file revealed the service plan dated 3-1-22 was completed for a change of condition. Continued record review revealed a Progress Note dated 3-1-22 indicated a change of condition nurse review was completed due to Tenant #5's frequent falls. It indicted Tenant #5 transferred independently to a one assist, to his wheelchair or walker.

When observed on 3-8-22 Tenant #5 was seated his wheelchair in the common areas. On 3-9-22 at 1:54 p.m. staff was observed propelling Tenant #5 in his wheelchair to the living room.

When interviewed on 3-9-22 at 2:01 p.m. the Nurse said it was 50/50 regarding Tenant #5's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0028	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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 395	Continued From page 11 use of the wheelchair or walker. Continued record review revealed the service plan dated 3-1-22 indicated reflected under Mobility/Escorts that Tenant #5 ambulated with one assist and a walker. It indicated Tenant #5 required escort assistance to and from the dining room and when it was noted he was walking independently. Tenant #5 often forgot his walker. The service plan under a.m. cares reflected staff ambulated Tenant #5 to the bathroom with his walker or using his wheelchair and assisted him with perineal care, grooming and dressing. The service plan did not reflect Tenant #5's use of the wheelchair with the exception of morning cares. 6. When interviewed on 3-9-22 at 2:01 p.m. the Nurse said current service plans were provided for the tenants listed above.	A 395		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or 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 interview and record review the Program failed to ensure staff completed eight hours of dementia-specific education and training within 30 days of employment. This pertained to 4 of 6 staff reviewed (Staff A, B, C and F). Findings follow:	A 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0028	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE CEDAR FALLS	5101 UNIVERSITY CEDAR FALLS, IA 50613

(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 545	Continued From page 12 1. Record review on 3-7-22 and 3-8-22 of Staff A's training documents revealed a hire date of 9-14-21. Staff A did not have eight hours of dementia-specific education completed within 30 days of employment. 2. Record review on 3-7-22 and 3-8-22 of Staff B's training documents revealed a hire date of 8-2-21. Staff B did not have eight hours of dementia-specific education completed within 30 days of employment. 3. Record review on 3-7-22 and 3-8-22 of Staff C's training documents revealed a hire date of 2-7-22. Staff C did not have eight hours of dementia-specific education completed within 30 days of employment. 4. Record review on 3-7-22 and 3-8-22 of Staff F's training documents revealed a hire date of 11-15-21. Staff F did not have eight hours of dementia-specific education completed within 30 days of employment. 5. When interviewed on 3-8-22 at 2:49 p.m. the Director confirmed all dementia specific education for the staff listed above was provided.	A 545		

OK 4-22-22

Plan of Correction
Cedar Falls Bickford Cottage

231C.5 Written Occupancy Agreement

Regulatory Insufficiency: The program failed to obtain occupancy agreements signed by the tenant or tenant's legal representative, prior to taking occupancy.

Plan of Correction:
The insufficiencies will be corrected as follows:

- Tenant #2 and Tenant #4 still reside in the community.

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

- Divisional Director of Resident Services provided re-education to the Director and Community Relations Director on regulation 231C.5 on 4/19/22.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Operations or designee with audit new resident files monthly x 90 days and prn thereafter during onsite visits.

Date deficiencies corrected by: 4/22/2022

A 345—481.67.9(4)b Staffing

Regulatory Insufficiency: The program failed to complete nurse delegated training within 30 days of employment.

Plan of Correction:
The insufficiencies will be corrected as follows:

- Staff A,C,D,E, and F delegations are completed by the RNC.
- Staff B no longer works for the program.

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

- Divisional Director of Resident Services provided re-education to RNC on state requirements for Nurse Delegation Procedures on 4/19/22.
- Director or designee will audit new hires monthly for compliance/completion with state required Nurse Delegation Procedures for 90 days and prn thereafter.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Resident Services or designee will audit new staff files monthly x 90 days and then twice per year to ensure compliance.

Date deficiencies corrected by: 04/22/2022

A 400 481-67.19(3) Record Checks

Regulatory Insufficiency: Program failed to complete a background check for staff prior to employment.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Staff D background check was completed on 4/19/22.

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

- Divisional Director of Resident Services provided education on 4/19/22 to the Director on Criminal Background Checks Policy.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Operations or designee will audit new hire staff files monthly for 90 days and then prn thereafter.

Date deficiencies corrected by: 04/22/2022

A 290 481-69.25(1)I Tenant Documents

Regulatory Insufficiency: Program failed to document nurse's notes by exception.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #2, Tenant #4 and Tenant #5 progress notes are documented by exception.

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

- Divisional Director of Resident Services provided education to the RNC on the Documentation Policy on 4/19/22.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Resident Services or designee will audit resident documentation monthly x 90 days and then twice per year to ensure documentation is by exception.

Date deficiencies corrected by: 04/19/22

A 355 481-69.26(2) Service Plans

Regulatory Insufficiency: Program failed to obtain a service plan signed by a tenant or tenant's legal representative prior to taking occupancy.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant # 2 service plan is signed and dated by all required representatives.

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

- Divisional Director of Resident Services provided re-education to the Director and RNC on the Service Planning and Agreements policy on 4/19/22.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Resident Services or designee will audit new move in resident's service plans monthly for 90 days and then twice per year to ensure service plans are signed by the tenant or tenant's legal representative prior to taking occupancy.

Date deficiencies corrected by: 04-22-2022

A 395 481-69.26.(4) a Service Plans

Regulatory Insufficiency: Program failed to develop service plans that reflected the identified needs of the tenants.

Plan of Correction:
The insufficiencies will be corrected as follows:

- Tenant C1 no longer resides in the community.
- Tenant #2 Service Plan was updated 4/19/22.
- Tenant #4 Ensure order has been discontinued.
- Tenant #5 Service Plan was updated 4/8/22.

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

- Divisional Director of Resident Services provided education to the RNC on the Service Planning and Agreements policy on 4/19/22.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Resident Services or designee will audit service plans twice per year to ensure resident needs and preferences are noted on service plan.

Date deficiencies corrected by: 04-22-2022

A545-481-69.30(1) – Dementia Specific Education for Personnel

Regulatory Insufficiency: Program failed to provide eight hours of dementia-specific education within 30 days of employment.

Plan of Correction:
The insufficiencies will be corrected as follows:

- Staff A, Staff B, Staff C, and Staff F will completed eight hours of dementia training by 4/19/22.

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

- Divisional Director of Resident Services provided education to the Director on the Dementia Training Policy on 4/19/22.
- Director will audit all current Staff files for non-compliance of dementia -specific training that did not occur within 30 days of hire.
- Director will assign any staff who is out of compliance with dementia-specific training to be completed by 5/12/22.
- Director will run bi-weekly reports in program's CMR to ensure dementia-specific training has been completed as assigned.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Operations or designee will audit program's CRM monthly to ensure eight hours of dementia-specific training has occurred for all staff within 30 days of hire.

Date deficiencies corrected by: 04/22/2022