STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IAALP026	A. BUILDING _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE URBANDALE	5915 SUTTON PLACE URBANDALE, IA 50322

(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 type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 12 Number of tenants with cognitive disorder: 11 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 9 TOTAL census of Assisted Living Program for People with Dementia: 32 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia. No regulatory insufficiencies were cited during the investigation of Complaints #101792-C and #109276-C.	A 000	**PLEASE SEE ATTACHED PLAN OF CORRECTION 3-27-23**	
A 195	481-69.23(1)i Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: i. Requires maximal assistance with activities of daily living	A 195		

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 195	Continued From Page 1 This Requirement is not met as evidenced by: Based on observation, interview, and record review the Program failed to discharge a tenant requiring maximal assistance with activities of daily living, thus exceeding level of care. This pertained to 2 of 5 tenants reviewed (Tenant #1 and Tenant #2). Findings follow: 1. Observations on 12-6-22 around 4:15 p.m. revealed Tenant #1 sat in her wheelchair and required assistance from her spouse to eat her meal. When prompted to use a cup or fork she made no attempt to use them. Additional observation on 12-7-22 at 12:15 p.m. Tenant #1 continued to require total assistance from staff for the noon meal. Record review on 12/7/22 of Tenant #1's Service Assessment and Service Plan dated 7/11/22 revealed she required extensive hand over hand assistance with dressing, grooming, and eating meals. She utilized a wheelchair for ambulation and required staff to move her within the unit. Staff managed her medications and activity schedule. Review of the Cognitive Assessment dated 7/11/22 revealed the Global Deterioration Scale scored a 7 and indicated very severe cognitive decline. 2. Observations on 12-6-22 around 4:15 p.m. revealed Tenant #2 sat in a geri-chair and required staff to move her around the unit. During the evening she required assistance to eat the meal and when prompted to use a cup or fork she made no attempt to use them. Additional observation on 12/7/22 at 12:15 p.m. revealed she required total assistance with the noon meal. Around 1:00 p.m. Staff D moved Tenant #2 to her room to lay her down and asked her to "hug" her	A 195		

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	IAALP026	A. BUILDING _____ B. WING _____	12/08/2022

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A 195	Continued From Page 2 to assist with standing. Tenant #2 made no attempt to do so and Staff D requested assistance from another staff to transfer her to the bed and completed peri-care. Record review on 12/7/22 of Tenant #2's Service Assessment and Service Plan dated 9/7/22 documented she required extensive hand over hand assistance with dressing, grooming, and eating meals and often refused assistance. She utilized a wheelchair for ambulation and required staff to move her within the unit. Staff managed her medications and activity schedule. Review of the Cognitive Assessment dated 9/7/22 showed the Global Deterioration Scale scored a 7 and indicated very severe cognitive decline. 3. When interviewed on 12/6/22 at 4:40 p.m. Staff B confirmed she transferred Tenant #1 and Tenant #2 with another staff. She said she felt it was not safe to transfer them with only one person except for Staff D who was strong enough to do so. She stated they both required total assistance with ambulation, toileting, dressing, grooming, medication administration, and activities. When interviewed on 12/7/22 at 11:15 a.m. Staff D stated she usually transferred both tenants by herself but at times required the assistance of another staff. She stated they both required total assistance with ambulation, toileting, dressing, grooming, medication administration, and activities. When interviewed on 12/6/22 at 4:40 p.m. Staff E acknowledged Tenant #1 and Tenant #2 required total assistance with ambulation, toileting, dressing, grooming, medication administration, and activities.	A 195		

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A 195	Continued From Page 3 On 12/7/22 at 1:22 p.m. the Registered Nurse Coordinator confirmed both tenants depended on staff for ambulation, dressing, grooming, toileting, medication administration, and activities due to their cognitive impairment. She stated neither tenant received hospice care at the time of the on-site visit and would request an evaluation.	A 195		
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 provide eight hours of dementia specific training within 30 days of employment. This pertained to 4 of 7 staff reviewed (Staff A, Staff B, Staff C, and Staff D). Findings follow: Record review of staff files on 12/6/22 revealed the following: 1. Staff A was hired 4/7/22 and completed 2.5 hours of dementia training in the first 30 days of employment. 2. Staff B was hired 6/7/22 and completed 1.5 hours of dementia training in the first 30 days of employment. 3. Staff C was hired 2/12/21 and completed 2.25 hours of dementia training in the first 30 days of employment.	A 545		

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A 545	Continued From Page 4 4. Staff D was hired 4/4/22 and completed .25 hours of dementia training in the first 30 days of employment. The Registered Nurse confirmed these findings on 12/6/22 at 2:55 p.m.	A 545		

Plan of Correction

Bickford Cottage of Urbandale

A195 481-69.23 (1)b Criteria for Admission/Retention of tenants

Regulatory Insufficiency: The program failed to discharge a tenant requiring maximal assistance with activities of daily living, thus exceeding level of care.

Plan of Correction:

The insufficiency will be corrected as follows:

- State Waiver completed and approved for Tenant #1 and Tenant #2.

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

- The Divisional Director of Health and Wellness provided re-education to the Executive Director and Health and Wellness Director on criteria for admission/retention of tenants on 3/24/2023.
- The Executive Director and Health and Wellness Director completed an all-staff in-service March 21. 2023, on criteria for admission/retention of tenants.

The program will monitor performance to ensure compliance as follows:

- The Health and Wellness Director will conduct a routine individual care core check to ensure program follows criteria for admission/retention of tenants.
- Divisional Director of Health and Wellness will audit individual care delivery checks to ensure resident retention are as required during onsite visits and prn.

481-69.30 (1) Dementia Specific Education

Regulatory Insufficiency: The program failed to provide eight hours of dementia specific training within 30 days of employment.

Plan of Correction:

The insufficiency will be corrected as follows:

- Staff A, B, C and D completed all dementia specific training on 12-30-22.

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

- Divisional Director of Operations provided education to Executive Director on Dementia Training Policy on 3/20/2023.

- Executive Director will audit all current staff files for dementia-specific training and will assign any staff who is out of compliance with dementia specific training to be completed by 3/27/23.
- Executive Director will complete bi weekly audits in program's CMR to ensure dementia-specific training has been completed as assigned for 90 days and as needed.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Operations or designee will audit programs CMR monthly for 90 days and as needed to ensure 8 hours of dementia-specific training has occurred for all staff within 30 days of hire.

Date of deficiencies to be corrected by: 3/27/23.