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
	S0042	A. BUILDING: _____ B. WING _____	C 02/19/2024

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

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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 impairment: 28 Number of tenants with cognitive impairment: 17 Total census: 45 The following regulatory insufficiencies were cited during the investigation of #115146-C, #115562-I and #113317-M.	A 000	See Attached POC 6/24/24	
A 130	481-67.2(1)e Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently follow established policy regarding the completion of incident reports. This pertained to 1 of 1 tenant identified in 113317-M. Finding follows: When interviewed on 2/6/24 at noon Staff K (former) reported she worked on 5/21/23 as the	A 130		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 130	Continued From page 1 medication aide in Mary B's area of the building from 2:00 p.m. - 10:00 p.m. When she arrived at work she realized the Program scheduled her to work alone. She said she talked to Staff B scheduled as the medication aide for the Assisted Living (AL) who agreed to assist in Mary B's. Staff K explained during the shift Tenant #2 became incontinent of urine and required assistance with changing. When she called Staff B for assistance Staff B could not assist due to a tenant fall in AL. Tenant #1 who had a history of falls had been restless and moving about the area. She had concerns he may fall while she assisted Tenant #2. She admitted she placed a gait belt loosely around Tenant #2's waist with his hands free. Staff K said she wanted to keep Tenant #2 safe when she used the gait belt to restrain Tenant #1 while she assisted Tenant #2. Staff K explained an Agency Staff (AS) arrived to the area and yelled at her for using the gait belt. AS J assisted briefly before she returned to the AL and left Staff K alone with 11 tenants. Record review on 2/12/24 revealed no incident report for a restraint incident involving Tenant #1 on 5/21/23. Further review of the Program's Incident reporting policy revised 10/2023 revealed incident or accidents should be reported immediately. When interviewed on 2/12/24 at 7:33 p.m. the Executive Director confirmed she could not locate a incident report.	A 130		
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.	A 150		

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A 150	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interviews and record review the Program failed to consistently follow procedures regarding response to door alarms. This pertained to 1 of 1 tenant (Tenant #4) identified in Incident 115562-I. Finding follows: Observations on 2/5/24 at 6:00 p.m. revealed the walkie talkie laid on a cabinet in the kitchen area of Mary B's. When questioned the three staff who worked did not have pager and/or walkie talkie with them. Record review on 2/1/24 revealed an Incident Report for Tenant #4, dated 9/8/23, and the Program's internal investigation. Staff documented they found Tenant #4 outside in the parking lot. The internal investigation included a statement from a former staff who asked staff how Tenant #4 got out of the building. Staff F told the former staff they heard the door alarm, but didn't see anyone so they reset the alarm. Staff F admitted she did not have the pager and/or walkie talkie. There were no injuries noted. Additional record review revealed Staff L's statement, dated 9/8/23 at 5:15 p.m. noted as she left the building she saw Tenant #4 in the parking lot of the building. He wore a coat and appeared he was ready to go somewhere. She walked him back into the building to the dining room of Mary B's for dinner. She asked staff how he was able to leave and they said they heard the door going off, but didn't see anyone so they reset the alarm. She asked Staff F where her pager and walkie were and she said they were in the	A 150		

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A 150	Continued From page 3	A 150		

kitchen. Staff L reminded Staff F they needed to be on her at all times and expressed to her if a door became ajar it would send an alert to the pagers. When that happened they needed to go immediately to whatever door alarmed and locate the resident after resetting the alarm. They also needed to let staff in the general population side know someone had eloped. Staff L gave Staff F a pager and told her to keep it on her. As she left, she encountered Staff M, who was also unaware Tenant #4 left. She reminded her she needed to have a pager on her, as well as walkie-talkie at all times.

Tenant #4's service plan, dated 9/5/23, revealed Tenant #4's diagnoses included Alzheimer's Disease, osteoarthritis, and failure to thrive. Tenant #4 had a Global Deterioration Score of five (5) and ambulated independently. Tenant #4's service plan documented increased aggression toward his wife and increased exit seeking behavior and noted a care conference would be scheduled to discuss care and service interventions.

Record review on 2/16/24 revealed Program procedures, Missing Unwitnessed Door Alarm Key Procedures, revised 4/2014. The document directed staff, if a door alarm occurred and staff member did not witness the event, to immediately check pagers for the type of alarm that occurred. Staff should also perform a visual search inside and outside the door area. The door alarm shall be silenced only "AFTER" all employees on duty were aware of the unwitnessed door alarm.

Repeated requests for Staff F's training associated with the pager system went unanswered by the Program.

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A 150	Continued From page 4 During the exit on 2/19/24 at 12:30 p.m. the administrative staff acknowledged Staff F failed to implement procedures regarding door alarms.	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 observations, interview and record review the Program failed to consistently treat tenants with consideration and personal dignity. This pertained to 4 of 4 tenants reviewed and potentially affected 5 of 5 of remaining tenants who resided in the Mary B's area of the Program. Findings follow: Observations on 2/5/24 from 4:00 p.m. - 4:46 p.m. revealed no staff interacted with Tenant #1 while he sat in a Broda chair. From 4:20 p.m. to 5:55 p.m. Tenant #3 sat in a Broda chair. At 4:46 p.m. staff moved Tenant #11's wheelchair without warning Tenant #11. At 5:00 p.m. staff loudly said Tenant #1's first name and added boy. From 5:10 p.m. to 5:40 p.m. three staff sat at a table feeding Tenants #1, #2 and #3 while talking amongst themselves. Several times during this time frame staff would say other tenants name loudly if they moved from the table where they had been eating. Examples included but not limited to, "(Tenant #9) where are you going? Sit down and	A 155		

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A 155	Continued From page 5 eat.", "Tenant #4 sit down and eat!", and "Tenant #3 wakey wakey!" Record review on 2/12/23 of the Program's resident handbook revealed the Program's primary goal of the staff at Bickford is to provide excellent services to our residents. All staff members work as a team, cooperating with residents' physicians and other outside care providers, to ensure that comprehensive and quality services are provided for all our residents. During the exit on 2/19/24 at 12:30 p.m. the administrative team acknowledged the findings.	A 155		
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 consistently ensure the availability of a sufficient number trained staff to meet the needs of tenants. This pertained to 1 of 1 tenant identified in Mandatory Abuse complaint 113317-M (Tenant #1) and potentially 10 of 10 remaining tenants who resided in Mary B's at the time of the incident. Finding follows: When interviewed on 2/6/24 at 12:00 p.m. Staff K (former) reported she worked on 5/21/23 as the medication aide in Mary B's area of the building from 2:00 p.m. - 10:00 p.m. When she arrived at work she realized the Program scheduled her to work alone. She said she talked to Staff B,	A 325		

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A 325	Continued From page 6	A 325		

scheduled as the medication aide for the Assisted Living (AL), who agreed to assist in Mary B's. Staff K explained during the shift Tenant #2 became incontinent of urine and required assistance with changing. When she called Staff B for assistance Staff B could not assist due to a tenant fall in AL. Tenant #1 who had a history of falls had been restless and moving about the area. She had concerns he may fall while she assisted Tenant #2. She admitted she placed a gait belt loosely around Tenant #2's waist with his hands free. Staff K said she wanted to keep Tenant #2 safe when she used the gait belt to restrain Tenant #1 while she assisted Tenant #2. Staff K explained an Agency Staff (AS) arrived to the area and yelled at her for using the gait belt. AS J assisted briefly before she returned to the AL and left Staff K alone with 11 tenants.

When interviewed on 2/12/24 Staff B confirmed Staff K worked alone in Mary B's the day of the incident.

Record review on 2/14/23 revealed staff assignment sheets for 5/21/24. Review of the assignment sheets revealed Staff A scheduled as medication aide from 2:00 p.m. - 10:00 p.m. and AS J as an aide in Mary B's. Staff A scheduled as medication aide in AL.

When interviewed on 2/6/24 at 2:11 p.m. the Director confirmed the Program had no documentation of AS's training from the agency. On 2/8/24 the Executive Director confirmed staff assignments but could not confirm AS J worked in Mary B's prior to her arrival during the incident.

During the exit on 2/19/24 at 12:30 p.m. the administrative team acknowledged one staff person to administer medications and assist 10

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A 325	Continued From page 7 tenants with Global Deterioration Scale (GDS) scores of 5 (moderately severe cognitive decline/early dementia) and 6 (severe cognitive decline/middle dementia) may not be a sufficient number of trained staff.	A 325		
A 340	481-67.9(4)a Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on interview and record review the delegating nurse failed to consistently ensure staff were sufficiently trained within 60 days of her employment. This pertained to 3 of 4 current staff (Staff B, C and D). Finding follows: Record review on 2/7/24 revealed the Program hired the delegating nurse on 11/28/23. Further reviewed revealed the delegating nurse failed to document a review or complete delegations within 60 days for Staff B, C, D. During the exit interview on 2/19/24 at 12:30 p.m. the administrative team acknowledged the	A 340		

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A 340	Continued From page 8 review/delegations had not been completed as required.	A 340		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified 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 delegating nurse failed to consistently ensure staff were sufficiently trained within 30 days of employment. This pertained to 4 of 4 former staff (Staff E, F, H and I). Finding follows: Record review on 2/8/24 revealed the following: a. Staff E hired 6/13/23, delegations completed delegations 8/4/23 b. Staff F hired 8/12/23, delegations completed 9/28/23 c. Staff H hired 6/12/23, delegations completed 7/18/23 d. Staff I hired 5/22/23, delegations completed 7/18/23 During the exit interview on 2/19/24 at 12:30 p.m. the administrative team acknowledged the Program failed to complete delegations as required.	A 345		

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A 380	Continued From page 9	A 380		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure staff received Dependent Adult Abuse (DAA) training as required. Chapter 235B.16 requires employees complete two hours of training relating to the identification and reporting of Dependent Adult Abuse within six months of initial employment and at least two hours of additional dependent adult abuse identification and reporting training every three years thereafter. This pertained to 4 of 4 staff (Staff A). Finding follows: Record review on 2/7/24 revealed the following DAA certificates: Staff A's DAA certificate dated 9/29/20 Staff B's DAA certificate dated 7/21/16 Staff C's DAA certificated dated 7/8/20 Staff D no DAA certificate During the exit on 2/19/24 at 12:30 p.m. administrative staff confirmed the Program had provided all training documentation requested.	A 380		
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	A 400		

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A 400	Continued From page 10 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 consistently perform criminal history and background checks prior to employment. This pertained to 1 of 1 staff (Staff K). Finding follows: Record review on 2/1/24 revealed the Program hired Staff K on 9/20/21. The Program provided a SING (Single Contact Registry) dated 1/30/24. When interviewed on 2/1/24 at 10:04 a.m. the Executive Director stated she could not locate another SING for Staff K.	A 400		
A 425	481-67.19(3)e Record Checks 67.19(3)e Employment pending evaluation. The program may employ a person for not more than 60 calendar days pending the completion of the evaluation by the department of human services if all of the following apply. The 60-day period begins on the first day of the person's employment. (1) The person is being considered for employment other than employment involving the operation of a motor vehicle; (2) The person does not have a record of founded child or dependent adult abuse; (3) The person has been convicted of a crime that is a simple misdemeanor offense under Iowa	A 425		

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A 425	Continued From page 11 Code section 123.47 or a first offense of operating a motor vehicle while intoxicated under Iowa Code section 321J.2, subsection 1; and (4) The program has requested an evaluation to determine whether the crime warrants prohibition of the person's employment. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure record check evaluations met the criteria for 60 day evaluation period. This pertained to 2 of 2 former staff reviewed with a criminal history (Staff H and I). Findings follow: Record review on 2/7/24 revealed a criminal history evaluation form for Staff H dated 6/19/23. Further review revealed the Program hired Staff H on 6/12/23. Staff H's criminal history included domestic abuse assault, domestic assault without intent causing injury and domestic assault second offense. Record review on 2/7/24 revealed the Program hired Staff I on 5/22/23. Staff I's criminal history included harboring a runaway against wishes of parent and interference with official acts no injury or damage. During the exit interview on 2/19/24 at 12:30 p.m. the administrative team acknowledged the Program failed to ensure record check evaluations were completed as required.	A 425		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's	A 145		

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A 145	Continued From page 12 functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed following a significant change in tenant condition. This pertained to 1 of 3 tenants (Tenant #3) reviewed who received hospice services. Finding follows: Record review on 2/8/24 revealed hospice services were initiated for Tenant #3 on 5/31/23. Additional record review failed to produce evaluations regarding this change in condition. When interviewed on 2/8/24 at 3:44 p.m. the Health and Wellness Director confirmed the Program failed to complete evaluations following Tenant #3's change in condition.	A 145		
A 195	481-69.23(1)i Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or	A 195		

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A 195	Continued From page 13 retained. A program shall not knowingly admit or retain a tenant who: i. Requires maximal assistance with activities of daily living This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the Program failed to consistently discharge tenants who exceeded admission/retention criteria, specifically requiring maximal assistance with activities of daily living. This pertained to 3 of 3 tenants observed being fed (Tenant #1-#3). Finding follows: Observations on 2/5/24 from 5:10 p.m. - 5:50 p.m. and 2/8/24 from 12:15 p.m. - 12:25 p.m. revealed staff fed Tenant #1, #2 and #3. Tenant #1 and #3 sat in a Broda chair. Tenant #2 used a wheelchair pushed by staff. On 2/5/24 Tenant #2 remained in the wheelchair while staff fed her. On 2/8/24 two staff assisted Tenant #2 to transfer to a dining chair. When interviewed on 2/8/24 two staff members said staff feed all three tenants at all meals, staff confirmed the tenants were dependent on staff for activities of daily living including; toileting, dressing, grooming, transfer and bathing. Record review on 2/7/24 revealed Tenant #1's Service Assessment (SA) dated 9/15/23. The SA noted Tenant #1 as totally dependent for all Activities of Daily Living (ADL). The SA specified Tenant #1 dependent in the following areas of ADLs; eating, bathing, grooming, dressing, transferring and toileting.	A 195		

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A 195	Continued From page 14 Record review on 2/7/24 revealed Tenant #2's Nurse Review dated 9/27/23. The nurse review documented Tenant #2 dependent on staff for all activities of daily living. Record review on 2/14/24 revealed Tenant #3's Hospice Certification and Plan of Care signed 1/27/24 by Suncrest Hospice's Doctor of Osteopathic Medicine (DO). Review revealed the DO documented Tenant #3 dependent on five of six activities of daily living. During the exit on 2/19/24 at 12:30 p.m. the administrative team acknowledged the findings regarding admission/retention criteria.	A 195		
A 330	481-69.25(1)q Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs) This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently maintain accurate documentation on task sheets for routine personal and/or health related care. This pertained to 9 of 9 tenants who resided in Mary B's (Tenants #1 - #9). Findings follow:	A 330		

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A 330	Continued From page 15 Record review failed to produce task sheets upon request of the survey. When interviewed on 2/12/24 at 2:32 p.m. the Executive Director was asked to provide task sheets for 2/5/24 2:00 p.m.- 10:00 p.m. shift for Tenants #1-#9. The Executive Director provided some task sheets and indicated, "That is all that was turned into me" when asked for the 2:00 p.m. - 10:00 p.m. sheets.	A 330		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the Program failed to consistently update service plans to meet tenants' needs. This affected 3 of 3 tenants (Tenants #1 - #3) reviewed who resided in Mary B's (Memory Care). Finding follows: Observations on 2/5/24 from 5:10 p.m. to 5:40 p.m. three staff fed Tenants #1, #2 and #3. Tenants #1 and #3 sat in Broda chairs.	A 350		

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A 350	Continued From page 16 Record review revealed the following: a. Tenant #1's service plan, dated 3/23/23, failed to include the need for assistance to eat meals and the use of Broda chairs. b. Tenant #2's service plan, dated 9/27/23, failed to include the need for assistance to eat meals and the use of Broda chairs. c. Tenant #3's service plan, dated 12/7/23, failed to include the need for assistance to eat meals and the use of Broda chairs. During the exit on 2/19/24 at 12:30 p.m. the administrative staff acknowledged the Program failed to ensure service plans included tenant identified needs.	A 350		
A 370	481-69.26(3)a Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure service plans were signed and dated. This pertained to 5 of 5 tenants who resided in Mary B's and were reviewed (Tenant #1-#5). Finding follows:	A 370		

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A 370	Continued From page 17 Record review on 2/12/24 revealed the following regarding tenants' service plans: a. Tenants #1's service plan, dated 3/23/23, did not include a signature or date. b. Tenant #2's service plan, dated 9/27/23, was not signed or dated. c. Tenant #3's service plan, dated 12/7/23, did not include a signature or date. d. Tenant #4's service plan, dated 9/5/23, was not signed or dated. e. Tenant #5's service plan, dated 12/11/23, was not signed or dated. The Program failed to obtain signatures with dates from all involved parties. During the exit on 2/19/24 at 12:30 p.m. the administrative team acknowledged the findings regarding signed service plans.	A 370		
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 observations, interview and record review the Program failed to consistently ensure service plans included tenant's identified needs and assistance needed. This pertained to 3 of 3 tenants (Tenants #1-#3) observed being fed. Findings follow:	A 395		

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A 395	Continued From page 18 Observations on 2/5/24 from 5:10 p.m. to 5:40 p.m. revealed staff fed Tenants #1, #2 and #3. Record review on 2/12/24 revealed the following: a. Tenant #1's service plan, dated 3/23/23, failed to include his need to be fed during meals. b. Tenant #2's service plan, dated 9/27/23, failed to include his need to be fed during meals. c. Tenant #3's service plan, dated 12/7/23, failed to include his need to be fed during meals. During the exit on 2/19/24 at 12:30 p.m. the administrative staff acknowledged the Program failed to ensure service plans included tenant identified needs.	A 395		
A 405	481-69.26(4)c Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: c. The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure tenant service plans included additional service providers. This pertained to 2 of 3 tenants (Tenants #2 & Tenant #3) who resided in Mary B's who received hospice services. Finding follows: Record review on 2/12/24 revealed the following: a. Tenant #2's service plan, dated 9/27/23, failed to include hospice services.	A 405		

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A 405	Continued From page 19 b. Tenant #3's service plan, dated 12/7/23, failed to include hospice services. When interviewed on 2/8/24 at 2:10 p.m. the Health and Wellness Director confirmed Tenant #2 & Tenant #3 received hospice services yet they were not included in the service plan.	A 405		
A 525	481-69.29(3) Staffing 69.29(3) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure all personnel including contract/agency staff were appropriately trained to meet the tenant needs. This pertained to 1 of 1 agency staff (Agency Staff J). Finding follows: Record review on 2/6/24 revealed Agency Staff (AS) J worked on 5/20/23 from 6:00 p.m. to 10:30 p.m. and 5/21/23 from 6:00 a.m. to 10:30 p.m. When interviewed on 2/6/24 at 2:11 p.m. the Director confirmed the Program had no documentation of AS J's training.	A 525		
A 535	481-69.29(5) Staffing 69.29(5) All programs employing a new program manager after January 1, 2010, shall require the manager within six months of hire to complete an	A 535		

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A 535	Continued From page 20 assisted living management class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living programs. Managers who have completed a similar training prior to January 1, 2010, shall not be required to complete additional training to meet this requirement. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure the Director completed required training within six months of hire. This pertained to 1 of 1 Director and potentially effect 45 of 45 tenants. Finding follows: Record review on 2/6/24 revealed the Program hired the Staff A as Director on 8/22/22. Additional record review failed to produce documentation regarding required training for managers. When interviewed on 2/8/24 at 8:01 a.m. the Regional Director of Operations confirmed the Program hired Staff A as Director on 8/22/22. When interviewed on 2/7/24 at 1:28 p.m. Director said she enrolled in the training on 2/7/24.	A 535		
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.	A 545		

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A 545	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure staff received eight hours of dementia- specific training within 30 days of employment. This pertained 4 of 4 former staff (Staff E, F, H and I). Findings follow: a. Record review on 2/7/24 revealed the Program hired Staff E on 6/16/23. The Program could not provide documentation of dementia specific training. b. Record review on 2/7/24 revealed the Program hired Staff F on 8/12/23. The Program could not provide documentation of dementia specific training. c. Record review on 2/7/24 revealed the Program hired Staff H on 6/12/23. The Program could not provide documentation of dementia specific training. d. Record review on 2/7/24 revealed the Program hired Staff I on 5/22/23. The Program could not provide documentation of dementia specific training. During the exit interview on 2/19/24 at 12:30 p.m. the Director acknowledged the Program failed to ensure staff received training as required.	A 545		
A 556	481-69.30(3)b Dementia-Specific Education for Personnel 69.30(3) Dementia-specific continuing education	A 556		

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A 556	Continued From page 22 b. Direct-contact personnel employed by or contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure all staff received eight hours of dementia-specific education annually. This pertained to 3 of 4 current staff (Staff B, C and D) and 1 of 1 former staff (Staff G) reviewed. Findings follow: Record review on 2/7/24 revealed the Program hired Staff B on 7/5/12. Review of documentation on 2/16/24 revealed Staff B failed to complete eight hours of training. Record review on 2/7/24 revealed the Program hired Staff C on 12/18/01. Review of documentation on 2/16/24 revealed Staff B failed to complete eight hours of training. Record review on 2/7/24 revealed the Program hired Staff D on 12/27/22. Review of documentation on 2/16/24 revealed Staff B failed to complete eight hours of training. Record review on 2/7/24 revealed the Program hired Staff G on 11/28/22. The Program could not provide documentation of dementia specific training. During the exit interview on 2/19/24 at 3:30 p.m.	A 556		

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A 556	Continued From page 23 the Director acknowledged the Program failed to ensure staff received training as required.	A 556		

BICKFORD COTTAGE URBANDALE
PLAN OF CORRECTION

A 130 481.67.2(1)e Program Policies and Procedures

Regulatory insufficiency: The program failed to consistently follow established policy regarding the completion of incident reports.

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

- Staff K no longer is employed by Bickford Senior Living
- Health and Wellness Director will provide education during training on incident reports and reporting upon all new employees.

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

- The Divisional Director of Operations will provide re-training to the Executive Director re the completion of incident reports.
- The Executive Director will conduct an all-employee in-service to review Bickford policies and procedures on incident report.
- The Executive Director will ensure all training is completed within 30 days of start date for all new employees

The program will monitor performance to ensure compliance as follows:

- The Executive Director will ensure compliance by reviewing training compliance routinely at branch visits

Date of deficiencies corrected by: 6/6/24

A 150 481.67.2(3) Program Policies and Procedures

Regulatory Insufficiency: The program failed to consistently follow procedures regarding response to door alarms

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

- Education provided on pagers and equipment by Executive Director, the branch will hold elopement drill

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The program will monitor performance to ensure compliance as follows:

- The Executive Director will conduct an in-service for all staff regarding Bickford Policy and Procedures relating to response to door alarms and elopement drills.
- The Director will ensure that all new hires have completed the required training within 30 days of hire.
- The Executive Director will ensure elopement drills are being completed on all shifts

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

- The Divisional Director of Operations will provide re-education to the Executive Director re Bickford policies and procedures regarding response to door alarms and elopement drills.
- The Director will ensure that all new hires have completed the required training within 30 days of hire.
- The Executive Director is responsible for ensuring Bickford policies and procedures regarding door alarms are followed and elopement drills are completed on all shifts at least quarterly.

The program will monitor performance to ensure compliance as follows:

- The Divisional of operations will ensure compliance by reviewing door alarms drills routinely while in branch two times for 2 months and annually thereafter.
- **Date of deficiencies corrected by: 6/24/2024**

A 155 481-67.3(1) Tenant Rights

Regulatory Insufficiency: The program failed to ensure tenants were consistently treated with respect and dignity.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Staff members from observation on 2/5/2024 will receive education regarding Tenant Rights on or before 6/21/24.

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

- Divisional Director of Operation will provide the Executive Director with reeducation on the Resident Bill of Rights.
- The Executive Director provided education to all staff on the Resident Bill of Rights on 6/18/24. Those staff not in attendance shall be provided with 1:1 training.

- The Executive Director, Health and Wellness Director or designee will provide training to new staff members, upon hire on Resident Bill of Rights.
- The Executive Director is responsible for ensuring residents are treated with consideration, respect and full recognition of personal dignity and autonomy.

The program will monitor performance to ensure compliance as follows:

- The Health and Wellness Director will interview residents during the assessment process regarding Resident Bill of Rights concerns and report to the Executive Director for investigation and follow-up.
- The Executive Director will investigate resident concerns brought to attention with the assistance of the Health and Wellness Director.
- The Divisional Directors of Operations and Health and Wellness will observe interactions with staff and Mary B's residents during routine visits two times two months and annually thereafter to ensure interactions comply with Tenant rights and residents are treated with consideration, respect, and full recognition of personal dignitiy and automony .
- The Divisional of Health and Wellness will review staff compliance of Signing Resident Bill of Rights while in the branch on routine visits.

Date of deficiencies corrected by: 6/21/24

A 325 481.67.9(4)a Staffing

Regulatory Insufficiency: The program failed to consistently ensure the availability of a sufficient number of trained staff to meet the needs of tenants.

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

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- The Executive Director and Health and Wellness Director are responsible for ensuring a sufficient number of trained staff are available at all times to fully meet tenants' needs.

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

- The Executive Director will ensure that training is completed within 30 days of the start of employment.
- The Executive Director will ensure that there are a sufficient number of employees trained staff to meet the tenants' needs.

The program will monitor performance to ensure compliance as follows:

- The Divisional Director of Health and Wellness and Divisional Director of Operations will ensure compliance by completing randoms checks of a sufficient number of trained staff while on branch visits 3 times three months and annually thereafter.

Date of deficiencies corrected by: 7/3/2024

A 340 481.67.9(4)a Staffing

Regulatory Insufficiency: The program failed to consistently ensure staff were sufficiently trained within the 60 days of employment.

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

- The Health and Wellness director will ensure all staff have been sufficiently trained and competent in all tasks that are assigned to within 60 days of their start date.

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

- The Executive Director will ensure that all staff have been sufficiently trained within 60 days of Health and Wellness Director start date.

The program will monitor performance to ensure compliance as follows:

- Divisional directors will complete routine checks on sufficiently trained staff within 60 days of the start date of the Health and Wellness Director and annually thereafter.

Date of deficiencies corrected by: 6/7/2024

A 345 481.67.9(4)b Staffing

Regulatory Insufficiency: the program failed to consistently ensure staff were sufficiently trained within 30 days of employment.

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

- The Health and Wellness director will ensure all staff have been trained and competent with delegation completed for all tasks assigned to withing 30 days of employment.

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

- The Executive Director will ensure that all staff have been sufficiently trained with required delegations completed within 30 days of employment.

The program will monitor performance to ensure compliance as follows:

- Divisional directors will complete routine checks on delegation documentation to ensure sufficiently trained staff within 30 days of Employment 2 times two months and annually thereafter

Date of deficiencies corrected by: 6/7/2024

A 380 481.67.9(6) Staffing

Regulatory Insufficiency: the failed to consistently ensure staff received Dependent Adult Abuse (DA) training as required.

Plan of Correction:

The insufficiencies will be corrected as follows:

- The Divisional Director of Operations will re-educate the Executive Director on the requirement that all staff receive Dependent Adult Abuse Training as required.
- The Executive Director is responsible for ensuring staff have received Dependent Adult Abuse training as required

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

- The Executive Director will ensure that two hours of training relating to identification and reporting of Dependent adult abuse has been completed withing 6 months of employment.
- The Executive Director will ensure that an additional two hours of training relating to identification and reporting of Dependent adult abuse has been completed every three years after initial training.

The program will monitor performance to ensure compliance as follows:

- Division Director of Operations will complete routine checks during branch visits to assure that initial and continued training has been completed with branch visits 2 times 2 months and at least annually thereafter.

Date of deficiencies corrected by: 6/21/2024

A 400 481.67.19(3)e Record Checks

Regulatory Insufficiency: the program failed to consistently perform criminal history and background checks prior to employment.

Plan of Correction:

The insufficiencies will be corrected as follows:

- The Divisional Director of Operations will re-educate the Executive Director on the requirements of checking criminal history and background checks prior to employment.
- The Executive Director will be responsible for ensuring criminal history and background checks are completed prior to employment.

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

- Director will ensure background check and perform criminal history on all new hires prior to employment and ensure proper documents are received and upload to personal file

The program will monitor performance to ensure compliance as follows:

- The Divisional Director of Operations will ensure background checks and criminal history has been completed prior to employment on routine branch visits 2 times two months and annually thereafter.

Date of deficiencies corrected by: 6/21/2024

A 425 481-67.19(3)e Record Checks

Regulatory Insufficiency: the Program failed to consistently ensure record check evaluations met the criteria for 60-day evaluation period.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Staff H and Staff I are no longer employed by Bickford Senior Living.
- The Executive Director will ensure that record check evaluations have met the criteria for 60-day evaluation periods

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

- Divisional Director of Operations will provide re-education to the Executive Director on requirement of record checks as required.

- The Executive Director will audit employee files to ensure that the record check evaluations have been completed and meet the criteria for 60-day evaluation periods.

The program will monitor performance to ensure compliance as follows:

- The Divisional of Operations will ensure that record check evaluations have met the criteria for 60-day evaluation periods by completing checks at routine branch visits. 3 times in three months.

Date of deficiencies corrected by: 6/21/2024

A 145 481-69.22(3) Evaluation of Tenant

Regulatory Insufficiency: The Program failed to complete evaluations as needed following a significant change in tenant condition.

Plan of Correction:

The insufficiencies will be corrected as follows:

- The Health and Wellness Director will evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed.

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

- Divisional Health and Wellness Director will educate the Health and Wellness Director upon hire, of the requirement to complete evaluations upon change in condition.
- The Health and Wellness Director will ensure and evaluate tenant's functional, cognitive and health status as needed.

The program will monitor performance to ensure compliance as follows:

- The Divisional Director of Health and Wellness will ensure each tenant's functional; cognitive and health status has been evaluated during routine visits three times three months and annually thereafter.

Date of deficiencies corrected by: 6/3/2024

A 195 481-69.23(1)i Criteria for Admission / Retention of Tenants

Regulatory Insufficiency: the Program failed to consistently discharge tenants who exceeded admission/retention criteria, specifically requiring maximal assistance with activities of daily living.

Plan of Correction:

The insufficiencies will be corrected as follows:

- The Health and Wellness Director will not admit or retain any resident that requires maximal assistant with activities of daily living. A program shall not knowingly admit or retain a tenant who Requires maximal assistance with activities of daily living including but not limited to residents requiring to be fed.

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

- The Divisional Health and Wellness Director will educate the Health and Wellness Director on state regulations of criteria for admission and retention of tenant for Assisted living.

- The Executive Director and Health and Wellness Director will be responsible for the review and following of state regulations related to meeting the criteria for admission and retention of tenant for Assisted living.

The program will monitor performance to ensure compliance as follows:

- The Divisional Director of Health and Wellness will review tenants during routine branch visits 3 times three months and annually thereafter, to ensure the branch follows state regulations for admission and retention of tenants.

Date of deficiencies corrected by: 6/10/2024

A 330 481-69.25(1)q Tenant Documents

Regulatory Insufficiency: the Program failed to consistently maintain accurate documentation on task sheets for routine personal and/or health related care.

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

- The Divisional Health and Wellness Director will educate The Health and Wellness Director upon hire of requirements to constituently maintain accurate documentation on task sheets for routine personal and/or health related care when the tenant is unable to advocate on the tenant's own behalf.

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

- The Health and Wellness Director will be responsible for ensuring that task sheets are available for tenant who are unable to advocate on the tenant's own behalf or the tenant has multiple service providers

The program will monitor performance to ensure compliance as follows:

- The Divisional Director of Health and Wellness will ensure that the tenant who is unable to advocate on the tenant's own behalf or the tenant has multiple service providers are being utilized during routine branch visits.

Date of deficiencies corrected by: 6/10/2024

A 350 481-69.26(1) Service Plans

Regulatory Insufficiency: the Program failed to consistently update service plans to meet tenants' needs.

Plan of Correction:

The insufficiencies will be corrected as follows:

- The Divisional Director of Health and Wellness will educate the Health and Wellness Director upon hire with the expectation that service plans are developed and updated as needed to meet the tenants' needs.
- The Health and Wellness Director will ensure service plans are developed for each tenant based on the evaluations and residents' current needs and updated as needed.

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

- The Health and Wellness Director will complete audits to ensure that service plans are developed for each tenant based on evaluations

The program will monitor performance to ensure compliance as follows:

- The Divisional Director of Health and Wellness will ensure that service plans are developed and updated to meet the needs of the residents based on service plan review during routine visits to branch three times three months and annually thereafter.

Date of deficiencies corrected by: 6/21/2024

A 370 481-69.26(3)a Service Plans

Regulatory Insufficiency: the Program failed to consistently ensure service plans were signed and dated.

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

- The Health and Wellness Director will ensure the service plan shall be signed and dated by all parties

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

- The Executive Director /designee will audit all service plans to ensure they are signed and dated by all parties.
- The Executive Director will ensure all parties have signed and dated the service plan at the time he/she signs.

The program will monitor performance to ensure compliance as follows:

- The Divisional Director of Health and Wellness will ensure all parties have signed and dated routine visits 2 times two months and annually thereafter.

Date of deficiencies corrected by: 6/4/2024

A 395 481-69.26(4)a Service Plans

Regulatory Insufficiency: the Program failed to consistently ensure service plans included tenant's identified needs and assistance needed.

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

- The Health and Wellness Director will ensure all identified needs and preferences are on the Service plan.

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

- Divisional Health and Wellness Director will educate the Health and Wellness Director uoon hire the requirement that each tenant’s service plan includes needs and assistance

- The Health and Wellness Director will be responsible for ensuring that needs are identified and met with evaluation on service plan

The program will monitor performance to ensure compliance as follows:

- The Divisional Directors will complete checks intermittently to ensure identified needs and preferences are on service plans during routine branch visits 3 times 3 months and annually thereafter.

Date of deficiencies corrected by: 6/4/2024

A 405 481-69.26(4)c Service Plans

Regulatory Insufficiency: the Program failed to consistently ensure tenant service plans included additional service providers.

Plan of Correction:

The insufficiencies will be corrected as follows:

- The Health and Wellness Director will be educated on state regulations of ensuring services plans include additional service providers.

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

- The Health and Wellness Director will be responsible for consistently ensuring tenant service plans include additional service providers.

The program will monitor performance to ensure compliance as follows:

- Divisional Directors will complete intermittent checks on service plans to ensure tenant service plans include additional service provider during routine branch visits X's 3 months and annually thereafter.

Date of deficiencies corrected by: 6/4/2024

A 525 481-69.29(3) Staffing

Regulatory Insufficiency: Program failed to consistently ensure all personnel including contract/agency staff were appropriately trained to meet the tenant needs.

Plan of Correction:

The insufficiencies will be corrected as follows:

- The Executive Director has been educated on responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population

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

- The Health and Wellness Director and Executive Director will ensure that all personnel employed by or contracting with the program receive training appropriate to assigned tasks.

The program will monitor performance to ensure compliance as follows:

- The Divisional Directors will complete audits for personnel employed by or contracting with the program who have received training per state regulations at routine branch visits at least annually.

Date of deficiencies corrected by: 6/6/2024

A 535 481-69.29(5) Staffing

Regulatory Insufficiency: Program failed to ensure the Director completed the required training within six months of hire.

Plan of Correction:

The insufficiencies will be corrected as follows:

- The Director will complete the required training by 7/31/24.

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

- Executive Directors will complete the required training within six months of hire.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Operation will complete routine check for compliance of required training within 6 months of hire date at routine visits.

Date of deficiencies corrected by: 7/31/2024

A 545 481-69.30(1) Dementia Specific Education for Personnel

Regulatory Insufficiency: Program failed to consistently ensure staff received eight hours of dementia- specific training within 30 days of employment.

Plan of Correction:

The insufficiencies will be corrected as follows:

- The Executive Director will complete audit to ensure staff have received eight hours of dementia-specific training within 30 days of employment

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

- The Executive Director will ensure staff have received eight hours of dementia-specific training within 30 days of employment

The program will monitor performance to ensure compliance as follows:

- The Division Directors will complete random audits at routine branch visits to ensure 8 hours of dementia-specific training has been completed within 30 days of new employment.

Date of deficiencies corrected by: 6/21/2024

A 556 481-69.30(3)b Dementia-Specific Education for Personnel

Regulatory Insufficiency: Program failed to consistently ensure all staff received eight hours of dementia-specific education annually.

Plan of Correction:

The insufficiencies will be corrected as follows:

- The Executive Director will complete an audit to ensure staff who have received eight hours of dementia-specific training receive at least eight hours of dementia-specific continuing education annually.

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

- The Executive Director will ensure staff receive a minimum of eight hours of dementia-specific continuing education annually.

The program will monitor performance to ensure compliance as follows:

- The Division Directors will complete random audits at routine branch visits to ensure 8 hours of dementia-specific training has been completed annually.

Date of deficiencies corrected by: 6/21/2024