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
	S0043	A. BUILDING: _____ B. WING _____	C 09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE WEST DES MOINES	5050 HAWTHORNE DR WEST DES MOINES, IA 50265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. General Population Number of tenants without cognitive disorder: 35 Number of tenants with cognitive disorder: 3 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 7 Total Census of Assisted Living Program for People with Dementia: 45 There were no regulatory insufficiencies cited during the onsite infection control survey. The following regulatory insufficiency was cited during the the investigation of Complaint 89775-C:	A 000		
A 039	481-69.23(1)b Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and 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: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by:	A 039		

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A 039	Continued From page 1 Based on observation, interview and record review the Program failed to ensure tenants who exceeded level of care were discharged. This pertained to 1 of 3 sample tenants (Tenant #1). Finding follows: Observations on 8/12/20 revealed several tenants seated in wheelchairs during the noon meal, including Tenant #1. On 8/19/20 at 11:50 a.m. observations revealed Tenant #1 sat in her wheelchair in her room while she visited with her son. At 12:25 p.m. staff pushed Tenant #1 to the dining room. Observations at 12:36 p.m. in the dining room revealed two staff assisted Tenant #1 into a dining room chair. At 1:05 p.m. staff approached Tenant #1 and encouraged her to eat. The staff was heard saying, "You aren't eating?" and offered her something else. When interviewed on 8/19/20 Staff A, B and C confirmed staff were told to make sure to transfer Tenant #1 into a dining room chair while this surveyor conducted observations. Staff A, B and C also confirmed they did not usually transfer Tenant #1 to a dining room chair for meals. Staff A, B and C also said Tenant #1 could not assist with transfer/toileting even if handrails were available. Two staff were needed to assist her with toileting; one to take pants down and one to perform peri-care. Record review on 8/12/20 revealed Tenant #1's Hospice Certification of Terminal Illness for 7/6/20 - 9/3/20. According to the document, Tenant experienced a generalized decline due to progressive Alzheimer's disease with associated diagnosis of dementia. She required maximal assistance with all transfers, ADLs (activities of daily living) and daily cares. When asked if Tenant #1 required maximal assistance with	A 039		

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A 039	Continued From page 2 transfers the Registered Nurse Coordinator (RNC) said she would get an updated certification document. Review of a verbal order dated 8/19/20 signed by Tenant #1's physician stated the tenant was no longer actively dying and could participate in feeding self along with putting clothing on upper body with cuing and prompting. Further review revealed the updated order did not address transfer status stated in the previous certification. When interviewed on 8/19/20 the Registered Nurse Coordinator (RNC) said she wasn't sure why staff did not transfer Tenant #1 from her wheelchair during meals other than it may just be easier. According to the RNC when staff assisted Tenant #1 in the bathroom two staff assisted; one staff to pull down pants and one to complete peri-care. During the exit interview on 9/23/20 the Program Director acknowledged that Tenant #1 had times she was less responsive, which may affect her ability to assist.	A 039		

Plan of Correction

West Des Moines Bickford Cottage

ok

A 039 481-69.23 (1)

Criteria for admission/retention of tenants.

Plan of Correction:

The insufficiency will be corrected as follows:

- Re-Education was completed on 3/15/21 with all BFM on the important of service plan implementation. All BFMs were instructed to notify the RNC or Director immediately with any changes to the care needs noted or desires of any resident. Education was also completed regarding the state regulation on the retention of a resident.

- Tenent #1 passed away on October 3, 2020.

- **The following measures will be taken to ensure the problem does not recur:**
  - The Director will ensure that annual in-service on these areas is completed as required and stated in our Policy and Procedure book/Emergency Handbook/Covid Guidelines, as well as ensuring that individual education is completed by the RNC as deemed necessary.

The program will monitor performance to ensure compliance as follows:

- Divisional leadership will audit annual In-services completed to ensure they areconducted as required.

Date deficiencies corrected by: 03/15/2021 and on-going