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 04/26/2021

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 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: 19 Number of tenants with cognitive disorder: 5 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 6 TOTAL census of Assisted Living Program for People with Dementia: 30 No regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of an Assisted Living Program. No regulatory insufficiencies were cited during the on-site infection control survey or the investigation of Incidents #92932-I and #93416-I.	A 000	See attached POC 7/22/21	
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 provide staff the required two	A 380		

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A 380	Continued From page 1 hours of dependent adult abuse training as required within six months of employment for 3 of 8 staff reviewed (Staff B, Staff C, and Staff E). Findings follow: Record review of staff files on 4-20-21 revealed the following: 1. Staff B was hired 8-24-2020. No dependent adult abuse training could be located. 2. Staff C was hired 12-4-18. Her previous training for dependent adult abuse expired and no current training could be located. 3. Staff E was hired 6-9-2020. No dependent adult abuse training could be located. The Director confirmed these findings on 4-20-21 at 3:19 p.m.	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 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 criminal, child, and dependent adult abuse background checks prior to employment for 2 of 8 staff reviewed (Staff C	A 400		

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A 400	Continued From page 2 and Staff D). Findings follow: Record review of staff files on 4-20-21 revealed the following: 1. Staff C was hired 12-4-18. A Single Contact License and Background Check was completed 4-22-19. 2. Staff D was hired 12-9-2020. A Single Contact License and Background Check was completed 2-26-21. The Director confirmed these findings on 4-20-21 at 3:19 p.m.	A 400		
A 155	481-69.23(1)b 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: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the Program failed to ensure tenants continued to meet criteria for retention of an assisted living program for people with dementia. This pertained to 2 of 4 tenants reviewed (Tenant #1 and Tenant #2). Findings follow: 1. Observation on April 19-22, 2021 at various times of the day revealed Tenant #1 seated in a	A 155		

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A 155	Continued From page 3 Broda chair with her legs elevated. Record review of Tenant #1's Cognitive Assessment dated 2-4-21 revealed she scored 6 on the Global Deterioration Scale and indicated Severe Cognitive Decline. Continued review revealed Progress Notes dated 2-4-21 documented she exhibited significant decline, no longer ambulated, utilized a wheelchair for mobility, and required 1-2 staff for transfers and generally required 2 staff. Further review revealed a verbal order from her hospice provider for a Broda chair to be used at all times for positioning and prevention of skin breakdown. Further review of hospice Interdisciplinary Group Meeting dated 3-31-21 revealed she was no longer ambulated and required a wheelchair for mobility. When interviewed on 4-20-21 at 11:37 a.m. Staff G stated Tenant #1 no longer ambulated and required staff to move her around in the Broda chair. When interviewed on 4-22-21 at 12:30 p.m. Staff H stated Tenant #1 utilized a Broda chair and required 1-2 staff for standing and/or transfers. She stated 2 staff were required most of the time. When interviewed on 4-20-21 at 3:14 p.m. the Registered Nurse Coordinator confirmed Tenant #1 required 1-2 staff for standing and/or transfers and required maximum assistance with mobility, transfers, medications, and activities. 2. Observation on 4-21-21 throughout the day revealed Tenant #2 seated in a wheelchair and made no attempt to move herself at any time. At 2:00 p.m. Staff H and Staff I moved her to her room and prompted her to grab the handrail in the bathroom. She placed her hands on the rail and	A 155		

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A 155	Continued From page 4	A 155		

made no attempt to stand when prompted. Staff H and Staff I placed their arm under each of Tenant #2's arms and asked her to stand as they assisted. Tenant #2 made no attempt to stand even with assistance.

Record review Tenant #2's Service Plan dated 2-8-21 revealed she required 1-2 staff assistance with mobility, transfers, and toileting. She required heavy verbal cueing and guidance when transferring and intermittent 2 person assistance especially for toileting. Further review revealed Progress Notes dated 2-8-21 documented a change in condition in mobility and she required additional assistance with activities of daily living. Continued review of Progress Notes dated 3-9-21 documented she failed to be accepted for physical therapy due to inability to stand for an extended amount of time and inability to retain knowledge of exercises.

When interviewed on 4-21-21 at 2:15 p.m. Staff H and Staff I stated Tenant #2 required 2 staff for transfers and for toileting.

When interviewed on 4-21-21 at 2:40 p.m. Staff J stated Tenant #2 required 1-2 staff for transfers. He performed a transfer without assistance in front of this surveyor. He confirmed other staff may need additional assistance at times due to her increased inability to bear weight.

When interviewed on 4-22-21 at 10:13 a.m. Staff F stated Tenant #2 required 2 staff for transfers.

When interviewed on 4-21-21 at 3:00 p.m. the Registered Nurse Coordinator stated Tenant #2 required intermittent 2 person assistance and stated staff use 2 for convenience when they could do it alone. She stated Tenant #2's ability to

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A 155	Continued From page 5 bear weight decreased recently and physical therapy denied to take her on as a patient due to her inability to stand. She confirmed Tenant #2 required maximum assistance with mobility, transfers, medications, and activities.	A 155		
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 the required eight hours of dementia specific training within 30 days of employment for 3 of 8 staff reviewed (Staff B, Staff D, and Staff E). Findings follow: Record review of staff files on 4-20-21 revealed the following: 1. Staff B was hired 8-24-2020. He completed 1.25 hours of dementia training within 30 days of employment. 1. Staff D was hired 12-9-2020. No dementia training within 30 days of employment could be located. 2. Staff E was hired 6-9-2020. No dementia training within 30 days of employment could be located.	A 545		

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A 545	Continued From page 6 The Director confirmed these findings on 4-20-21 at 3:19 p.m.	A 545		

ok

Plan of Correction

West Des Moines Bickford Cottage

August 2, 2021

A 380 481-67.9 (6) Staffing

Regulatory Insufficiency: The Program failed to follow policies and procedures established by the Program for dependent adult abuse training.

Plan of Correction:

The insufficiency will be corrected as follows:

- Staff B -Dependent Adult Abuse Training was completed on 4/30/21
- Staff C- Dependent Adult Abuse Training was completed on 4/30/21
- Staff E- Dependent Adult Abuse Training was completed on 4/30/21

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

- The Director will ensure that all new hires have completed the required training within 6 months, a tracking log was created to keep all trainings current.

The program will monitor performance to ensure compliance as follows:

- Divisional director of operations will audit employee files to ensure dependent adult abuse training has been completed as required.

A 400 481-67.19 (3) Record Checks

Regulatory Insufficiency: The Program failed to follow policies and procedures established by the Program for performing criminal and abuse record checks through the State.

Plan of Correction:

The insufficiency will be corrected as follows:

Staff C- Record Check on file.
Staff D- Record check on file. During a personal chart audit in 2/2021 this file was noted to not have a background check on file. A new one was completed at that time.

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

- The Director will ensure that all new hires have completed the required record check before hire. A tracking log was also created to keep all record checks current and trackable.

The program will monitor performance to ensure compliance as follows:

- Divisional director of operations will audit employee files to ensure record checks have been completed as required.

A 155 481-69.23 (1)b Criteria for Admission/Retention of tenants

Regulatory Insufficiency: The Program failed to follow policies and procedures established by the Program for retaining a resident who requires routine two-person assistance with standing, transfer, or evacuation.

Plan of Correction:

The insufficiency will be corrected as follows:

- The Director and RN Coordinator completed an all-staff mandatory in-service on April 29th 2021 reviewing the policy regarding two-person routine assistance and education regarding two-person physical transfers. All staff were educated to notify the nurse immediately if a resident requires a routine two-person transfer.
- A waiver was completed and sent for review.

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

- The Director and RN Coordinator will report to Divisional any resident that is requiring routine two-person assistance more than 50% of the time for direction.
- The RN Coordinator will conduct a routine individual care check to ensure the policy is retained.

The program will monitor performance to ensure compliance as follows:

- Divisional director of resident services will audit individual care delivery checks to ensure resident retention are as required.

A 545 481-69.30 (1) Dementia Specific Education

the Program by not providing 8 hours of dementia training within the first 30 days of hire.

Plan of Correction:

The insufficiency will be corrected as follows:

- Staff B- Completed, beyond the 30 days. Current on all training as of 5/1/2021.
- Staff D- Completed, beyond the 30 days. Current on all training as of 5/1/2021.
- Staff E- Completed, beyond the 30 days. Current on all training as of 5/1/2021.

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

- The Director will ensure that all new hires have completed the dementia training within 30 days of hire. A tracking log was also created to keep all dementia training current and trackable

The program will monitor performance to ensure compliance as follows:

- Divisional director of resident services will audit resident files annually to ensure dementia education have been completed as required.

Date deficiencies corrected by: 07.22.2021 and on-going