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
	S0024	A. BUILDING: _____ B. WING _____	C 10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 10 Tenants with cognitive impairment: 15 Total census: 25 This Program has met criteria to be an Assisted Living Program for People with Dementia by definition for the last two recertification visits (5/29/25). No regulatory insufficiencies were cited during the investigation of Complaint #130042-C and Complaint #130556-C. The following regulatory insufficiencies were cited during the investigation of Incident #129801-I, Incident #130066-I and Complaint #130320-C.	A 000	See attached POC 11/26/25	
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:	A 130		

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A 130	Continued From page 1 Based on interview and record review the program failed to complete an incident report for 1 of 9 current tenants reviewed following a fall (Tenant #2). Findings follow: Record review on 10/6/25 revealed an Investigation Form, dated 7/24/25, completed after Tenant #2 suffered multiple rib fractures. Tenant #2 fell in the dining room on 7/17/25 when she missed the chair and fell on her bottom. She was assessed by the nurse and given Tylenol for pain. Tenant #2 was able to walk, but experienced pain when laying down or attempting to stand from a seated position. She was found on the floor inside her apartment on 7/20/25 with her head by the bathroom by Staff C. Staff D checked her vitals and physical condition. Staff D reported no injuries to the on-call nurse because Staff C told her the pain was not new, but related to her fall on 7/17/25. Staff C said she did not complete an incident report as she thought it was the responsibility of Staff D who was the Medication Technician. Program staff failed to complete an incident report describing Tenant #2's fall on 7/20/25. The Divisional Director of Health and Wellness confirmed these findings on 10/6/25 at 4:30 PM.	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. This REQUIREMENT is not met as evidenced by:	A 150		

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A 150	Continued From page 2 Based on observation, interview and record review the program failed to follow the established Medication Administration policy, affecting 2 of 2 discharged tenants (Tenant C1 and Tenant C2) and 4 of 9 current tenants reviewed (Tenant #1, Tenant #3, Tenant #6 and Tenant #9). Findings follow: 1) Record review on 9/30/25 revealed Tenant C2 moved to the program on 8/1/25. A progress note from 8/4/25 identified he arrived at the building on 8/1/25 at 4:45 PM. The (former) Health and Wellness Director (HWD) reviewed his orders from the hospital and went over a list of medication with his daughter. She "got them set up for the weekend and discussed them with the medication aide". A review of an August 2025 Medication Administration Record (MAR) showed staff began to administer GNP Century Tab, Losartan, Preservision Areds 2, SMZ-TMP DS (antibiotic) and Tramadol to Tenant C2 on 8/2/25 (the day after his admission), medications which were all listed on the 8/1/25 hospital discharge paperwork. On 8/4/25, the program received admission orders for Tenant C2 from a nurse practitioner which included the medications Amitryptyline, Aspirin, Carboxymethylcellulose, Gabapentin, Levothyroxine, Nutritional supplement (Ensure Plus) and Vitamin D3. The HWD did not add these medications to the MAR. The HWD added Amlodipine to the MAR on 8/5/25, which was on the 8/1/25 discharge list. Tenant C2 had an initial service plan dated 8/11/25 (completed late) which noted he needed full assistance with medication. During an interview with Staff B on 10/1/25 at	A 150		

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A 150	Continued From page 3 1:03 PM she reported the HWD would direct her to administer pills to Tenant C2 which were not on the MAR. She would not do this and asked the HWD to administer those pills. Tenant C2's family would tell her he used to get more pills than what she was providing to him such as Gabapentin but these medications were not on the MAR so she was unable to do so. Tenant C2's daughter was interviewed on 10/1/25 at 8:40 AM and expressed gratitude for the staff at the program, but confirmed her father did not receive all his pills during his stay at the program. They also gave him pills at the wrong time which caused him to be lethargic. The program failed to administer all prescribed medication to Tenant C2, even when provided a complete medication list on 8/5/25. 2) Tenant C1 moved to the program for a respite stay on 7/29/25. On 8/20/25, the HWD documented in a progress note Tenant C1 was not taking her medication correctly. The HWD instructed the medication aid to begin administering her pills on this date. She discharged from the building on 8/26/25. A service plan dated 8/7/25 noted staff would provide medication reminders to Tenant C1 daily, which included storing her medication in a safe manner. It was not clear if program staff started administering Tenant C1's pills on 8/20/25 or if this began earlier. There was no record of what medication staff administered to Tenant C1. Staff B was interviewed on 10/1/25 at 1:03 PM and confirmed she would watch Tenant C1 take	A 150		

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her medication from a pill planner when she initially moved in. Later in her stay, the HWD brought the pill planners to the medication room and instructed staff to administer the pills.

The sister of Tenant C1 was interviewed on 10/1/25 at 9:02 AM and reported when her sister moved to the program she set up the pills in a medication box. She would send her sister pictures of the medication box each morning as a reminder of the need to take the pills. When the sister visited in the afternoon, the morning pills would still be in the medication box. Due to the concern about Tenant C1 not taking her pills, she asked the program to begin administering the medication. Once they did so, there did not seem to be additional issues.

The program failed to maintain a MAR to document what medication staff administered to Tenant C1 when they assumed responsibility for this task.

3) Tenant #6 moved into the building on 8/17/25. The HWD created an initial service plan for her on 9/1/25 (late) noting she required full assistance with medication management. A review of records revealed there was no Aug. MAR for Tenant #6. A September 2025. MAR indicated staff did not document the administration of medication to Tenant #6 until 9/5/25.

On 9/29/25 at 11:15 AM Staff A was interviewed and recalled when Tenant #6 moved to the program a medication planner with her pills was put in the medication room along with three bottles of medicine. There was no MAR or paper

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A 150	Continued From page 5 list of medication for about 2.5 weeks. Staff A would not administer medication to the tenant without a list so she believed the tenant did not receive her pills at times. Staff A reported her concerns to the HWD multiple times. During an interview on 10/6/25 at 10:10 AM the private caregiver for Tenant #6 said she had provided services to the tenant twice weekly each morning from the time she moved to the program. Until 10/5/25, the private caregiver would go to the building medication room to pick up the cup of Tenant #6's medication as staff did not bring the pills to her apartment. The private caregiver would then watch the tenant take her medication. The private caregiver stated the tenant took her pills when she was present, but heard this was not always the case for Tenant #6's other private caregivers. She did not know what those private caregivers did with the pills the tenant would not take. The Divisional Director of Health and Wellness wrote Medication Error Reports for Tenant #6 for the dates 8/17/25 - 9/2/25 indicating the HWD failed to obtain medication orders from the doctor. The HWD directed employees to administer medication without medication orders or a MAR. The program had no system of ensuring Tenant #6 received medication as prescribed during her early stay at the program. Staff were handing her pills to private duty caregivers and asking them to administer them to Tenant #6. 4) Record review on 10/21/25 of a progress note from Tenant #9's Nurse Practitioner (NP) on	A 150		

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A 150	Continued From page 6 8/11/25 indicated she was seen for ongoing concerns of depression and tearfulness. She was taking Citalopram (an antidepressant). Tenant #9 reported increased sadness for varying reasons. The NP discontinued the Citalopram and prescribed Sertraline (an antidepressant). A review of the August, 2025 MAR for Tenant #9 showed the following: - The program stopped administering Citalopram to Tenant #9 on 8/11. - Program staff administered Sertraline to Tenant #9 on 8/12, 8/13, 8/14, 8/15, 8/17 and 8/18 (she refused the medication on 8/16). The medication was marked "no supply" on 8/19 - 8/28. Staff made additional notes on the MAR such as "not here" on 8/19 and "reordered" on 8/26. - Tenant #9 received her Sertraline on 8/29/25 and ongoing. During the period when Tenant #9 did not have her Sertraline, an Incident Report dated 8/25/25 identified Tenant #5 placed a urine-filled incontinence brief in her microwave and turned it on. Staff entered her room when they noticed a burning smell. On 8/27/25 the HWD documented she was going to set up an appointment with the NP as Tenant #9 was constantly crying and displaying agitation toward another female tenant. These behaviors had not improved with medication. The program failed to administer medication as prescribed to Tenant #9, who displayed behaviors of increased aggression and increased depression.	A 150		

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A 150	Continued From page 7 5) Record review on 10/21/25 of a face sheet for Tenant #1 revealed she was diagnosed with Hypertension. Tenant #1 provided the program with a medication list when she moved in on 7/1/25, which included Amlodipine, 2.5 mg, 2 tablets at bedtime. Amlodipine is a prescription medication used to treat high blood pressure. Tenant #1's August, 2025 MAR indicated she was to take 1-5mg. tablet of Amlodipine every night at bedtime. She received this medication from 8/1/25 - 8/18/25. Staff documented on 8/19 - 8/25, 8/28 and 8/29 there was no supply of the medication and it had been reordered. The program failed to provide Amlodipine to a tenant with a diagnosis of hypertension for nine days due to it not being refilled in a timely manner. 6) During an interview with Tenant #3 in his apartment on 10/1/25 at 9:55 AM, two medication cups were present. One cup contained two pills and another cup held one pill. Tenant #3 explained these were pills he did not want to take at the times the medication aides came to his apartment to administer his medication. He reported the staff would leave these pills with him at his request. Tenant #3 had a Home Health Nurse who visited him twice a month and as needed. When interviewed on 10/1/25 at 10:35 AM, she stated during her last two visits (the last one which occurred on 9/19/25) she found medication sitting on the table by his chair. Tenant #3 had a service plan dated 9/11/25	A 150		

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A 150	Continued From page 8 which noted he required full assistance with medication administration. There was no indication staff could leave medication at his bedside. 7) The Program's Medication Administration policy noted program staff would take the medication to the individual tenant, remove the drug from the package and follow the procedure for administration of medication. Drugs would be prepared and administered by the same person. Staff would ensure the tenant was identified prior to the administration of the drug and the person who administered the medication was the one who recorded it on the MAR. If the tenant did not take the medication, staff should notate this information. Caregivers should observe tenants' reaction to their medication. An accurate, up-to-date MAR would be maintained and list all the medication to be stored and administered by the program. During an interview on 10/22/25 the Divisional Director of Health and Wellness confirmed tenants did not receive their medication as prescribed.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate.	A 160		

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A 160	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide appropriate services to 2 of 9 current tenants reviewed (Tenant #2, and Tenant #9). Findings follow: 1) A. Record review on 9/29/25 revealed an Investigation Form, dated 7/24/25, due to Tenant #2 experiencing multiple rib fractures. Tenant #2 had a fall on 7/17/25 in the dining room when she missed the chair and fell on her bottom. She was assessed by the nurse and given Tylenol for pain. Tenant #2 was able to walk, but experienced pain when laying down or attempting to stand from a seated position. On 7/20/25 Staff C found Tenant #2 on the floor near the bathroom inside her apartment. Staff D checked Tenant #2's vital signs and physical condition. Staff D reported no injuries to the on-call nurse because Staff C told her the pain was not new, but related to her fall on 7/17/25. On 7/24/25, staff reported to the on-call nurse and Executive Director Tenant #2 was in severe pain and in bed. The on-call nurse directed them to call the Power of Attorney (POA) and ask if she could go to the hospital. The POA picked up Tenant #2 and transported her to the ER where she was diagnosed with multiple rib fractures and a UTI. A review of progress notes revealed the following: - on 7/17/25 the former Health and Wellness Director (HWD) identified Tenant #2 had a fall when sitting at the dining room table. She was assessed by the HWD and no injuries were	A 160		

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found. Tenant #2 was able to move all extremities.
- Tenant #2 continuously struggled when getting out of chairs and trying to stand up on 7/23/25. She reported her ribs and lower back hurt.
- The HWD documented on 7/24/25 at 6:12 PM she was aware Tenant #2 fell when trying to sit at the dining table. She was sore from this and should be provided pain medication or an ice pack. This was documental after Tenant #2 was admitted to the hospital.
- The HWD documented on 7/27/25 she was informed via email Tenant #2's POA took her to the Emergency Room (ER) and she had fractured ribs. It was unclear when this happened as she was not witnessed falling, however she had not been using her walker the majority of the day. Staff should escort her to meals.

Tenant #2 presented at the Emergency Room on 7/24/25 at 4:15 PM. The ER admission record identified she was a 78 year old female with a history of advanced dementia, hypertension, chronic kidney disease and prior history of hip fracture. She was brought to the emergency room due to recent falls. A urinalysis was grossly abnormal. A CT check of the abdomen and pelvis was obtained to evaluate for any injuries and showed acute fractures of the right ribs 7 - 12 with varying degrees of cortical offset, segmental of the 9th and 10th ribs. She was admitted for pain management and treatment of her urinary tract infection. Tenant #2 returned to the program on 7/28/25.

Interviews conducted with staff on 7/30/25 during the program investigation included the following:
- Staff F (who worked 7/18, 7/19, 7/20, 7/22, 7/23

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and 7/24) remembered when she worked on 7/18/25, Tenant #2 was complaining of pain in her ribs. When she went to stand her up for the day Tenant #2 was screaming in pain. She said she needed to see a doctor three times. Staff F reported this to the HWD and medication aide.
- Staff A (who worked 7/17, 7/18, 7/21, 7/22 and 7/23) was present when Tenant #2 had her fall in the dining room. She missed the chair and ended up on the floor. Tenant #2 immediately started complaining of rib pain after being picked up. Staff A described the HWD as dismissive of Tenant #2's reports of pain. She continued to report pain and asked to see a doctor for multiple days until she was taken to the hospital by her POA.
- Staff G (who worked 7/18, 7/19, 7/20, 7/21 and 7/23) recalled helping Tenant #2 out of a rocking chair when she was working on 7/18/25. She complained of her back and sides hurting. Tenant #2 couldn't stand without assistance. Every step she took was painful. Dressing and undressing caused her pain.

On 10/6/25 at 2:25 PM Staff G reported Tenant #2 had a fall on 7/17/25 and again on 7/18/25 at which time she was found by Staff H. This was reported to the HWD. She was concerned because Tenant #2 experienced increased urinary incontinence and pain. She wouldn't attend activities and was crying out in pain. Staff G believed Tenant #2 should have gone to the hospital earlier, but on 7/24/25, she talked with the Executive Director about what could be done. She was directed to contact the POA. Staff G believed she went to the Executive Director because the HWD was on vacation.

Tenant #2's POA was interviewed on 10/2/25 at

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A 160	Continued From page 12 11:00 AM. She reported she was not notified of her cousin's fall on 7/17/25, but heard the nurse assessed her. Staff usually did inform her when Tenant #2 fell. Then there was another fall on 7/20/25, of which she also was not made aware. It was her understanding the nurse was on vacation when the second fall occurred. She received a call on 7/24/25 informing her Tenant #2 should probably go to ER. By then her cousin was in horrific pain and screaming when they tried to get her in the car. The program failed to have a nurse assess Tenant #2 when she was experiencing days of pain and requesting to be seen by a doctor. They did not complete an incident report and notify her physician following her second fall. The HWD reported she was aware the tenant was experiencing pain and staff should provide pain medication and ice to treat her symptoms, but not until after she was in the hospital. The program failed to promptly provide care when she had falls and reported pain. B. Tenant #2's POA also reported in her interview on 10/2/25 at 11:00 AM concerns regarding what occurred after her cousin experienced urinary incontinence at night. The POA stated there were multiple times she discovered the sheets and bedspread pulled up over urine soaked sheets. Staff made Tenant #2's bed without putting on clean sheets. The POA stated after this occurred several times she shared the information with the Executive Director and HWD, but it continued to happen. In order to ensure her cousin had a dry bed to sleep in, she hired a private duty caregiver to go to the program three days a week.	A 160		

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A 160	Continued From page 13 Tenant #2's private duty caregiver was interviewed on 10/6/25 at 10:44 AM. She reported times as recently as two weeks ago when she entered the apartment and found Tenant #2's bed made and the bottom sheets soaked with urine. She generally arrived at the building at 12:30 PM. There were times she would enter and find Tenant #2 sitting in her chair naked. Other times the tenant would be sitting at lunch with her incontinence briefs drenched and a pool of urine in the chair. The caregiver spent four hours with Tenant #2 three times a week and had never found the tenant to soak through a brief within four hours when she was in her care. A review of Tenant #2's service plan dated 8/8/25 identified Tenant #2 chose to sleep late in the morning but staff should help get her dressed before 11:00 AM. They should assist her to use the toilet and ensure she was wearing a clean incontinence garment. Staff were to provide routine toileting assistance before meals. Staff were to check her linens upon waking and ensure they were clean and dry before making her bed. On 10/6/25 at 2:25 PM Staff G stated she had discovered tenants' beds which were saturated with urine or feces but the sheets were pulled up over the mess. She reported staff did this when they made the beds of Tenant #4 and Tenant #7. On 10/6/25 at 3:15 PM Staff H reported when she put tenants such as Tenant #7 to bed she would find a chux pad placed over feces with the sheets and his bed spread pulled over them. The bed appeared fully made. She did not believe Tenant #7 would be able to make his bed due to his cognitive impairment.	A 160		

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A 160	Continued From page 14 During an interview with the HWD on 10/21/25 at 5:48 PM she reported she received reports of staff covering up soiled bedding. She said she would find towels over soiled areas of sheets. The HWD reported this to the Executive Director. Tenant #4 had a service plan dated 9/29/25 indicating he required full assistance with all aspects of bathroom activities. Staff needed to assist him with peri cares. He had an incontinence bed pad he used to protect his sheets. Tenant #4 scored a 5 on the Global Deterioration Scale indicating a moderately severe cognitive decline. Tenant #7 had a service plan dated 9/23/25 indicating his laundry would be washed as needed if his linens were soiled. He scored a 6 on the Global Deterioration scale indicating a severe cognitive decline. During an interview with the Executive Director on 10/22/25 at 2:48 PM she stated she was aware of concerns with the wet sheets on Tenant #2's bed but did not know this was an issue for other tenants. She thought interventions had been put in place, but couldn't recall what they were, and there were no longer any issues. She confirmed these were human errors. The program failed to ensure standard, sanitary living conditions were maintained to ensure the health of the tenants served. 2. Record review on 10/21/25 of a progress note from Tenant #9's Nurse Practitioner (NP) on 8/11/25 indicated she was being seen for	A 160		

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ongoing concerns of depression and tearfulness. She was taking Citalopram (an antidepressant). Tenant #9 reported increased sadness for varying reasons. The NP discontinued the Citalopram and prescribed Sertraline (an antidepressant).

A review of the August, 2025 MAR for Tenant #9 showed the following:
- The program stopped administering Citalopram to Tenant #9 on 8/11.
- Program staff administered Sertraline to Tenant #9 on 8/12, 8/13, 8/14, 8/15, 8/17 and 8/18 (she refused the medication on 8/16). The medication was marked "no supply" on 8/19 - 8/28. Staff made additional notes on the MAR such as "not here" on 8/19 and "reordered" on 8/26.
- Tenant #9 received her Sertraline on 8/29/25 and ongoing.

During the period when Tenant #9 did not have her Sertraline, an Incident Report dated 8/25/25 identified Tenant #5 placed a urine-filled incontinence brief in her microwave and turned it on. Staff entered her room when they noticed a burning smell. On 8/27/25 the HWD documented she was going to set up an appointment with the NP as Tenant #9 was constantly crying and displaying agitation toward another female tenant. These behaviors have not improved with medication.

The program failed to administer medication as prescribed to Tenant #9 while the Tenant exhibited increased aggression and increased depression.

The Divisional Director of Health and Wellness confirmed Tenant #9 did not receive her

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A 160	Continued From page 16 medication as prescribed on 10/22/25 at 9:33 AM.	A 160		
A 175	481-67.3(5) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67/3(5) To receive from the manager and staff of the program a reasonable response to all requests. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to provide a reasonable response to requests from 3 of 9 current tenants reviewed or their representatives and 1 of 3 discharged tenants reviewed or their representatives (Tenant #1, Tenant #2, Tenant #3 and Tenant C2). Findings follow: 1) An interview was conducted with Tenant #3's Power of Attorney on 10/1/25 at 1:45 PM in which she reported staff at the program made a number of promises, but did not follow through on the care they promised to provide. She asked three times for the program to provide a chart in Tenant #3's apartment about his bowel regimen, urine output and frequency of his showers to assist with communication between the program and the Home Health nurse. The chart was not put up. She added concerns she has called the building frequently and no one answered the phone. During an interview with Tenant #3's Home Health nurse (HH nurse) on 10/1/25 at 10:35 AM she described he had experienced a heart attack	A 175		

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at the program. He also had a bowel issue which required him to be on a strict bowel regimen. Tenant #3 had a catheter and was at risk for urinary tract infections. They tried to do a simple input/output sheet in his apartment as a form of communicating what was happening with his health. When there was no information on the tracking form the HH nurse would ask staff what was happening with Tenant #3 and they would tell her they could not provide this information. The HH nurse talked with the former Health and Wellness Director (HWD) and Divisional Director of Health and Wellness about getting staff to complete this information but staff wouldn't do it. Due to Tenant #3's cardiac history, it was important to track basic information about his vitals, urine input/output and bowels.

Tenant #3 had a Resident Assessment dated 2/12/25 in which it was identified he had a record for urine output as well as a bowel movement record on which he could record his bowel movements. They were in his apartment for use. The HH nurse would use them as well.

2) Tenant #2's cousin was interviewed on 10/2/25 at 11:00 AM and stated she complained a number of times to the Executive Director and HWD about staff not getting her cousin up for lunch. She also talked to them about drawing the top sheet up over her soiled fitted sheet. Due to these issues not being addressed, they hired someone to come in three times a week to ensure Tenant #3 got to lunch and her bed was clean and dry. Her other concern was it was impossible to reach someone. She would send the Executive Director and HWD texts and emails. When she called the building she was unable to reach a person unless it was lunchtime.

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A 175	Continued From page 18 Generally, the Executive Director would call her back within a day of her phone call. 3) Tenant #1's daughter was interviewed on 9/30/25 at 5:20 PM and voiced her frustration when staff at the program did not answer the phone when she called. She ended up leaving work on 9/30/25 after she called so many times without an answer to ensure her mother was safe. Recently, Tenant #1's husband was in his wife's apartment over the noon hour and knew she did not have lunch. There was also a camera in the room verifying this information so she knew her mom did not have lunch. She called and asked if her mom ended up getting a lunch tray and was told her mom was in the dining room during the noon hour. These issues have caused her to lose trust in the program. 4) During an interview with Tenant C2's daughter on 10/1/25 at 8:43 AM she reported billing concerns she addressed with the Executive Director and Family Advocate. The daughter said she called and sent many emails to the Family Advocate without a response. Program staff failed to be available to tenants and their representatives to meet their daily needs as well as those addressed on assessments. On 10/1/25 at 11:30 AM the Divisional Director of Health and Wellness confirmed there were issues with the telephones being answered in a timely manner which she would address. On 10/2/25 at 11:45 PM she confirmed there was no evidence staff were tracking Tenant #3's urine input output.	A 175		

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A 340	Continued From page 19	A 340		
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 program's newly hired nurse failed to ensure all certified and noncertified staff were trained, affecting 1 of 9 current tenants reviewed (Tenant #3) and potentially affecting 25 of 25 tenants. Findings follow: 1) Tenant #3 was admitted to the program on 11/7/24. He was diagnosed with neurogenic bowel and bladder. The program referred Tenant #3 to a Home Health agency for management of catheter cares. Record review on 10/3/25 of Home Health notes for Tenant #3 revealed he was admitted to their program on 11/18/24 to assist with catheter cares. The Home Health Registered Nurse was working with the patient and his caregiver to 1) prevent urinary tract infections and 2) to care for his Foley catheter. The catheter care included the cleaning of the	A 340		

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urinary meatus (the external opening of the urethra, the tube that carries urine from the bladder to the outside of the body). These interventions began on 11/18/24 and continued through the time of the investigation.

The Home Health nurse documented on 2/4/25 Tenant #3's Foley catheter was functioning well. He was not always compliant with his catheter cares. An employee of the program reported they assisted with catheter cares two times daily. He had been treated for a urinary tract infection within the previous 14 days. Tenant #3 needed assistance from someone at the time of the assessment to maintain his toileting hygiene. The Home Health nurse recommended staff to perform pericare twice daily and if the area was soiled with soap and water and then dry it well.

The program had a catheter care delegation to direct staff on how to aid in preventing bladder infection from urine retention. Routine catheter care should include cleansing the perineal area and catheter insertion site twice daily and securing the catheter strap to the thigh to prevent trauma. Staff were to inspect the catheter where it entered the tenant for encrusted material or drainage. They should cleanse the perineal area with warm water and soap, then pat dry. Using povidone-iodine swabs (or soap and water), they should cleanse the outside of the catheter and tissue around the meatus, avoiding contamination of the urinary tract by wiping away from the urinary meatus. Using a dry gauze pad, they should remove any encrusted materials on the catheter tubing.

Tenant #3's Home Health nurse (HH nurse) was interviewed on 10/1/25 at 10:35 AM and

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discussed concerns about his genitals being thoroughly cleaned putting him at risk for urinary tract infections. Shortly after she began taking care of Tenant #3 she asked one of the program staff what they did when performing catheter care. The employee said she came in and emptied the catheter drainage bag. The HH nurse asked if the staff cleaned the catheter and the employee said she did not do this. The HH nurse believed there was a deficit of knowledge. She offered to provide education to the staff but received no response from the program. The agency has provided a bath aide to attempt to supplement the cares.

On 10/1/25 at 2:14 PM Staff I stated when giving Tenant #3 a shower she cleaned around his catheter tubing. However, he did all of his toileting himself and didn't require her assistance with cleaning his perineal area. She emptied his catheter bag.

During an interview with Staff K on 10/22/25 at 2:00 PM she reported Tenant #3 was very independent. She emptied his catheter bag, but he was able to complete the rest of his toileting cares on his own.

The former Health and Wellness Director (HWD) stated on 10/21/25 at 5:48 PM during an interview staff did great demonstrating how to provide catheter cares during their skills check ups, but she did not believe this occurred when she was not around.

On 9/30/25 at 11:15 AM Staff A reported when interviewed the HWD did not meet with her to ensure she was properly trained, or delegated, to meet the responsibilities of her position.

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A 340	Continued From page 22 Staff H stated in an interview on 10/6/25 at 2:25 PM she was not delegated by any nurse in the two years she worked at the program. The HWD watched her perform catheter cares and reportedly said she would sign her off. On 10/1/25 at 2:14 PM Staff I reported the HWD watched her provide incontinence cares to a tenant and may have considered this to be a full delegation. Staff I did not review any other skills with the HWD. She confirmed she wasn't a Certified Nursing Assistant. Staff J was interviewed on 10/1/25 at 1:10 PM and reported she was not delegated by the former HWD. On 10/1/25 at 11:30 PM the Divisional Director of Health and Wellness reported that even though she was unable to find proof the HWD had delegated staff, she believed this occurred. She confirmed the reports from staff they were not delegated by the HWD.	A 340		
A 345	481-69.25(3) Tenant Documents 69.25(3) All records shall be protected from loss, damage and unauthorized use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to protect Medication Error Report forms and task sheets from loss potentially affecting 25 of 25 tenants. Findings follow: 1) Record review on 10/21/25 revealed the program did not have a Medication Room and	A 345		

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A 345	Continued From page 23 Cart Audit form for the month of August. On 10/21/25 at 1:45 PM, the Health and Wellness Director (HWD) from a sister building stated she delegated Staff E on 10/20/25 to ensure he was trained on administering medication. Staff E was removed from this task due to reports from the former HWD he made a number of medication errors right before she ended her employment (her final day in the building was 8/27/25). During an interview with the Family Advocate on 10/21/25 at 3:40 PM she recalled working the day the former HWD met with Staff E to discuss how he made a large number of medication errors and how Staff B made two medication errors. The former HWD reportedly became upset when Staff E questioned him about the errors and kicked him out of her office. Staff E later told the Family Advocate no one ever explained the errors to him. The former HWD was interviewed on 10/21/25 at 5:48 PM and stated she completed a full audit of the medication cart on 8/21/25. Upon completion of the audit she found medication cards with pills in them which weren't administered to tenants. When she researched why the pills weren't given to the tenants, the Medication Administration Record (MAR) indicated the medicine was provided to the individuals. The former HWD wrote up Medication Error Report forms to reflect these errors. She recalled Staff E made eleven medication errors and Staff B made two medication errors, but said there were 16 medication errors in total. The former HWD sent a picture of three plastic bins with the medication cards and completed Medication Error Forms to	A 345		

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the monitor verifying her statement. The HWD said she left the bins and forms in her office when she ended her employment.

Interviews conducted with the Divisional Director of Health and Wellness on 10/21/22 and 10/22/25 revealed there were no Medication Audits in the online portal for the month of August. She also stated there were no Medication Error Report forms for the month of August for anyone other than Tenant #6 (and these reports were completed by the Division Director of Health and Wellness in September). The former HWD contacted her on 8/20/25 stating there were medication errors and she felt overwhelmed. She encouraged the former HWD to go home and do the write-ups from home. When she entered the former HWD's office on 9/3/25, there were no Medication Error Report forms. She asked the Executive Director about the forms and was told no one had seen them. The Divisional Director of Health and Wellness stated the former HWD should have uploaded the Medication Error Report forms into the tenants' charts.

2) Record review on 10/21/25 of task sheets for the requested dates of 9/1/25 - 9/15/25 revealed the program only maintained the documents for 9/2/25, 9/6/25, 9/8/25, 9/9/25 and 9/15/25. The program's daily task sheets included information about tasks completed for each tenant, they were not individualized.

On 10/21/25 at 3:20 PM the HWD from a sister building confirmed the program did not maintain task sheets for tenants for three years as all

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A 345	Continued From page 25 requested information could not be located.	A 345		
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 ensure service plans were developed prior to signing the occupancy agreement and taking possession of an apartment for 1 of 1 discharged tenants reviewed (Tenant C2) and 2 of 3 current tenants reviewed who were admitted since 6/1/25 (Tenant #5 and Tenant #6). Findings follow: 1. Record review on 9/29/25 revealed Tenant C2 moved to the program on 8/1/25 and signed the occupancy agreement on 8/3/25. An initial service plan was not developed and signed until 8/11/25. 2. Additional record review on 9/29/25 revealed Tenant #5 moved to the program on 6/4/25 and signed the occupancy agreement on 6/16/25. The initial service plan was not signed at the time of the investigation.	A 355		

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A 355	Continued From page 26 3. Continued record review on 9/29/25 revealed Tenant #6 moved to the program on 8/17/25. Her occupancy agreement was not ever signed. The initial service plan was developed and signed by her legal representative on 9/1/25. These findings were confirmed by the Divisional Director of Health and Wellness on 10/2/25 at 11:45 AM.	A 355		
A 360	481-69.26(3) 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to update the service plan within 30 days and with a significant change for 1 of 1 current tenants reviewed who admitted within the previous four months (Tenant #1). Findings follow: Tenant #1 moved to the program on 7/1/25. An initial service plan was dated 6/28/25. Record review on 9/30/25 of progress notes revealed the following: - On 8/15/25, Tenant #1 refused to take her medication. When Staff C asked for the	A 360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0024	A. BUILDING: _____ B. WING _____	C 10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

(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 360	Continued From page 27	A 360		

medication back from the tenant, she slapped the employee in the face and grabbed her scrubs.
- It was noted on 8/21/25 Tenant #1 was getting agitated and aggressive after dinner. She would wander, exit-seek and go into other tenants' rooms asking for their help to leave the building.
- Tenant #1 became agitated and grabbed another tenant and yelled at her on 9/26/25.

On 9/30/25 at 8:40 AM, Staff D was interviewed and reported experiencing one episode with Tenant #1 in which she was scratched, punched and bit.

Staff H was interviewed on 9/30/25 at 4:30 PM and stated Tenant #1 was known to act out aggressively by hitting, kicking and biting. This could happen a few times a week. It started shortly after she moved to the program.

When interviewed on 10/1/25 at 1:10 PM Staff J said Tenant #1 slapped her in the face on 9/28/25 when she did not want to take her medication. She generally displayed aggressive behavior when she was sundowning.

Tenant #1 had a service plan dated 8/5/25. The plan identified she had memory impairment, poor safety awareness and used poor judgement. Tenant #1 needed full assistance with medication administration but there was no mention of her refusing to take medication. Her plan was not updated to address her aggressive behaviors or medication refusal. The 8/5/25 service plan was not written within 30 days of her admission.

The Divisional Director of Health and Wellness confirmed these findings on 10/2/25 at 11:45 AM.

ok
11/12/25

Bickford of Ames plan of correction.

1.A130 (481-67.2(1e) – Corrective action section: Program policies and procedures.

Deficiency cited: Program staff failed to complete an incident report following a fall.

Corrective action steps:

- All staff providing care will be trained on how to complete incident reports in the electronic health record immediately after the incident occurs.
- The health and wellness director will review all reported incidents and ensure that they are documented accurately in the electronic health record
- . The staff member who observes the incident will complete the incident report in the electronic health record and notify the Health and Wellness Director immediately.
- The health and wellness director will conduct follow-up calls with the POA and the primary provider following the incidents.
    - **Responsible staff member for corrective action**: The Divisional of Health and Wellness and the interim Health and Wellness Director from the sister branch.
    - **Timeline:** Two weeks of submitting POC.
    - **Action:** The health and wellness director will ensure that all staff members who provide direct care are trained in documenting all incidents that occur in the electronic health record.
    - Divisional director of health and wellness will review all incidents on a weekly basis to ensure compliance.
    - **2. A150 (481-67.2(3) Program policies and procedures**

Deficiency cited: Failure to follow the established medication administration policy affecting 2 discharged tenants (tenant C1 and tenant C2) and 4 of 9 current tenants (Tenant #1, Tenant #3, Tenant #6 and Tenant #9)

Corrective action steps: The health and wellness director, who was responsible for ensuring that all orders were faxed and medications were available at the branch, was terminated from Bickford. Tenant 1 and Tenant 2 no longer reside at Bickford.

Tenant 6 has an updated MAR. All new orders were obtained and faxed to the pharmacy on September 4th.

Tenant 3 has requested to have the medication that he requests to have by his bedside changed to as needed, as he states that he does not need it every day. A request has been sent to his primary care provider.

The incoming health and wellness director will be trained in Medication Administration Policy. This training will include completing weekly audits and ensuring all the medications ordered are in the building within 24 hours of being ordered. All pharmacy paperwork will be faxed to the pharmacy promptly for all new admits before they arrive in the building. All medications administered to all residents will be recorded in the Medication Administration Record. All new tenants will be discussed weekly in the higher path meeting for at least 30 days.

The Health and Wellness director from the sister branch and the Divisional Director of Health and Wellness will ensure that all paperwork is faxed to the pharmacy promptly for all new orders, including new tenants' orders, that all signed physicians' orders are also faxed to the pharmacy, and that all orders in the MAR are accurate and up to date. All medication aides will be delegated and instructed to notify the on-call nurse before documenting "medications not available,". The medication aides will be educated on the importance of observing the six rights of medication administration, including not handing the medication to another person to administer who is not authorized to do so. The medication aides who prepare the medication will ensure that they administer it to the correct tenant and verify that the tenant swallows the medication. Medications will be administered in accordance with the doctor's orders.

- **Responsible staff member for corrective action**: The Divisional Director of
- Health and Wellness and the Health and Wellness director from the sister branch.
- **Timeline:** Within two weeks of submitting the plan of correction.
- **Action:** The Divisional Director of Health and Wellness will complete weekly audits to ensure the tenants are getting medications as ordered. The divisional director of health and wellness will ensure all new orders for all admits are sent to the pharmacy promptly in the absence of a health and wellness director. The divisional director, in conjunction with the health and wellness director from a sister branch, will complete delegations for the medication aides, as the branch currently does not have a Health and Wellness Director. The Divisional Director of Health and Wellness will run a daily medication exception report to ensure that medications not administered are followed up on appropriately. After Health and Wellness Director is hired, they will complete the delegations for the staff within 60 days of the hire date.

3. A160 (481-67.3(2) Tenants Rights.

Deficiencies cited:

1. **Failure to have the nurse assess the tenant when she was experiencing pain and requesting to see the doctor.**

Corrective action steps: The Health and Wellness Director will assess the residents if there is a change in their condition. The POA will be notified of the change of condition and will make the final decision after discussing with the Director of Health and Wellness. The tenant will be sent to the emergency room contingent upon the assessment completed by the Health and Wellness Director and discussion with the POA. The primary provider will be notified of any changes in condition, including hospitalizations.

2. **Failure to ensure standard, sanitary living conditions are maintained to ensure the health of the tenants served.**

Corrective action steps: The Health and Wellness Director from the sister branch will conduct random checks on sampled residents who are incontinent and ensure that all bedding is changed after incontinent episodes. Delegations on perineal care and bed changing will be completed for all caregivers.

3. Failure to administer medications as ordered.

Corrective action steps: All medication aides will be delegated and instructed to notify the on-call nurse before documenting medications that are not available. The medication aides who prepare the medication will ensure that they administer it to the correct tenant and verify that the tenant swallows the medication. Medications will be administered in accordance with the doctor's orders. The Divisional Director of Health and Wellness will run a daily medication exception report and complete follow-up appropriately in the absence of the Health and Wellness Director.

- **Responsible staff Member**: The Divisional Director of Health and Wellness and the interim Health and Wellness Director from the sister branch. The incoming Health and Wellness director will complete delegations within 60 days of their hire date.

- **Timeline**: Two weeks of submitting this plan of correction.

- **Action:** Delegations will be completed for all staff who provide direct care to the tenants. The incoming Health and Wellness director will complete delegations within 60 days of being hired to all staff who provide direct care to the tenants.

4. A175 (481-67.3(5) Tenants Rights.

Deficiency cited: The program failed to provide a reasonable response to requests to three tenants.

Corrective action steps: A service plan meeting was held with tenant 3's POA on October 17th. She was notified that staff could not track tenant 3's bowel and urine output due to the assisted living regulations. The nurse stated that the tenant could track his bowel movements and urine output if he wished to do so and would notify the caregivers and nurse immediately of any concerns. The nurse would complete the assessment following his concerns. The POA verbalized agreement.

The Health and Wellness Director will follow up with POAs and tenants to provide updates on the service plan and will request a meeting to discuss any changes reflected in the plan. The POA or tenant will then sign the service plan.

A meeting will be held with Tenant 3's home health care company to review Bickford's expectations and ALF regulations regarding what can be done at the branch and what they, as a home health care company, can assist with, while both adhering to the assisted living regulations.

Delegations will be completed on all direct care staff on how and when to complete bed changes.

New mobile phones were provided for staff, enabling them to receive phone calls when someone calls the branch easily. In the absence of the executive director, the family advocate will receive calls that are not answered at the branch after the fifth ring on the executive director's work cellphone.

The breadbasket manager will maintain a list of residents who attend meals. The caregivers will ensure that all their assigned residents come to the dining room, unless they are scheduled to receive room trays. Staff will document if the resident refuses to come out for meals.

All families will be provided with the executive director's phone number and email address, allowing them to reach out to her with any concerns easily. All families will be provided with a telephone number at the main office, whereby they can call if they encounter any issues or problems that are not addressed at the branch level.

Responsible staff members: The Health and Wellness Director, Breadbasket manager, and the Executive Director.

Timeline: Two weeks of submitting the plan of corrective action.

Action steps: The Executive Director will respond to all emails and phone calls from family members within 24 business hours. The Executive Director will ensure that all concerns of family members are addressed promptly and effectively. Family members will be provided with the information to contact the main office if their problems are not

addressed to their satisfaction. The Executive Director will ensure all staff members are trained on the expectation of answering the phones.

The Health and Wellness Director will discuss with the POAs and the tenants the services that can be offered within the assisted living setting. The service plan will outline the services provided, and the POA or tenant will sign the service plan after reviewing it together. The Health and Wellness Director will follow up with the breadbasket manager on a weekly basis to obtain the attendance log for all residents who visit the dining room to eat.

5. A340(481-67.9(4) a Staffing.

Deficiency cited: The program's newly hired nurse failed to ensure all certified and non-certified staff were trained.

Corrective action steps: Delegations will be completed for all staff who provide direct care to the tenants. The incoming Health and Wellness Director will complete delegations within 60 days of being hired to all staff who provide direct care to the tenants.

- **Responsible staff member for corrective action**: The Divisional of Health and Wellness and the interim Health and Wellness Director from the sister branch. The incoming Health and Wellness director will complete delegations within 60 days of their hire date.
- **Timeline**: Two weeks of submitting this plan of correction and 60 days after the new health and wellness director is hired.
- **Action steps:** The Divisional Director of Health and Wellness and the interim Health and Wellness Director from the sister branch will complete all delegations for all licensed and unlicensed caregivers. The incoming Health and Wellness director will complete delegations within 60 days of their hire date.
  The Health and Wellness Director from the sister branch and the Divisional Director of Health and Wellness will ensure that all staff present sign the delegation packet, which the nurse will also sign.

6. A345(481-69.25(3) Tenants' documents.

Deficiency cited: The program failed to protect medication error report forms and task sheets from loss, potentially affecting tenants.

Corrective action steps: Weekly medication room audits will be completed. The Health and Wellness Director will complete a daily medication exception report.

The Divisional Director of Health and Wellness will complete a weekly medication exception report and the medication room audit.

All medication errors will be logged in the electronic health record. The POA and primary providers will be notified immediately of the medication errors. The medication aides will be taught how to complete medication error reports in Quick MAR and report them to the nurse immediately.

All direct staff will complete all care provided in the electronic health records in the computer. The previous paper task sheets utilized by staff will be stored for a period of three years.

Responsible staff member for corrective action: The Health and Wellness director and the Divisional Director of Health and Wellness.

Timeline: Two weeks of submitting this plan of correction and 60 days after the new health and wellness director is hired.

Action: The Divisional Director of Health and Wellness will conduct weekly audits to ensure that the medication room audits are completed on a weekly basis. All medication errors will be reviewed during the weekly higher path meeting, which will be attended by the Health and Wellness Director, the Divisional Director of Health and Wellness, the Executive Director, and the Family Advocate.

7. A355(481-69.26(2) Service plans.

Deficiencies cited: The program failed to ensure service plans were developed before signing the occupancy agreement and taking possession of the apartment.

Corrective actions: Service plans will be reviewed and signed by the Health and Wellness Director, POA, or tenant prior to the tenant moving into the building. The Executive Director will ensure that the service plan is signed prior to the occupancy agreement being signed. The Executive dDrector will ensure that all incomplete occupancy agreements are reviewed and signed by the POA and or tenant.

Responsible staff members for corrective action: The Wealth and wellness Director from the sister branch, the Divisional Director of Health and Wellness, and the Divisional Director of Operations.

Timeline: Two weeks of submission of this plan of correction.

Action: The Executive Director will ensure that the service plan is signed by both the Health and Wellness Director and the POA or tenant. The Health and Wellness Director will complete the assessment and will meet with the POA or tenant to review and sign the service plan prior to the tenant moving in.

The Divisional Director of Health and Wellness will conduct audits on all new tenants scheduled to move in and ensure that all service plans are signed before their move-in date.

The Divisional Director of Operations will ensure that all pending occupancy agreements are reviewed and signed by the POA. Afterwards, the Divisional Director of Operations will conduct weekly audits of sampled residents' charts and subsequently every 90 days to ensure compliance.

8. A360(481-69.26(3) Service plans.

Deficiencies cited: The program failed to update the service plan within 30 days of a significant change.

Corrective action steps: Tenant's one service plan will be reviewed and updated, reflecting her aggressive behaviors and refusal to take her medications.

- **Responsible party for corrective action**: The Divisional of Health and Wellness and the interim Health and Wellness Director from the sister branch. The incoming Health and Wellness director will complete delegations within 60 days of their hire date, the Divisional Director of Operations and the Executive Director.
- **Timeline**: Within 7 days of this POC submission.
- **Action**: Conduct a comprehensive assessment to reflect on any changes that occur with all residents. The Divisional Director of Health and Wellness will train the incoming Health and Wellness Director on the assessment process, including, but not limited to, updating service plans in response to significant changes in condition. The Divisional Director of Health and Wellness will also conduct weekly audits of sampled residents' charts and subsequently every 90 days to ensure compliance.