STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0008	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE FORT DODGE	1536 20TH AVENUE N FORT DODGE, IA 50501

(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 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: 16 Tenants with cognitive impairment: 7 Total census: 23 This Program has met criteria to be an Assisted Living Program for People with Dementia by definition for the last two recertification visits. No regulatory insufficiencies were cited during the investigation of Complaint #129366-C. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program.	A 000	See attached POC 11/18/25	
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 services plans following significant changes for 2 of 4 sample tenants (Tenant #1 and Tenant #2). Findings follow:	A 360	**1.A360 Corrective Action Section: Service Plans 481(69.26(3)** **Deficiency cited: The Program failed to update service plans following significant changes for tenant one and tenant two.** **Corrective action steps:** 1. Tenant's one service plan will be reviewed and updated to reflect her unsteady gait and preference of sitting outside in the sun, which increases temperature. Her POA and primary provider will be notified of the tenant's preference. A face-to-face service plan meeting will be held with the POA to discuss the current service plan of care,	

			which will include the pros and cons of the tenant sitting outside for prolonged periods of time. Orders for physical, speech, and occupational therapy were retrieved and uploaded to the electronic health record. All assessments will be completed promptly to reflect the change in conditions that have occurred for all residents. Tenant two passed away. o Responsible party for corrective action: The Health and Wellness Director. o **Timeline**: Within 7 days of this POC submission. o **Action**: Conduct a comprehensive assessment to reflect on any changes that occur with all residents. The divisional director of health and wellness will re-educate the Health and Wellness Director on the assessment process including but not limited to updating service plans following significant changes in condition and will conduct weekly audits of sampled residents' charts and subsequently every 90 days to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0008	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE FORT DODGE	1536 20TH AVENUE N FORT DODGE, IA 50501

(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 1 1. Record review on 8/27/25 for Tenant #1 revealed the following: a. Progress note, dated 6/04/25, indicated Tenant #1 needed "to be watched", because she sat in the courtyard in the sun and her body temperature increased to 100 to 102 degrees. According to the progress notes, dated 6/08/25 and 6/11/25, Tenant #1 sat in the courtyard in the sun and refused to come inside. A progress note on 6/28/25 indicated Tenant #1 was unsteady and almost fell when she came indoors. The note suggested she should be encouraged to stay indoors when it was hot and humid outside. b. Tenant #1's current service plan, dated 6/04/25, revealed no information concerning Tenant #1 being outside in the heat. During an interview on 8/27/25 at 11:25 a.m., the Registered Nurse (RN) stated management staff discussed with staff regarding Tenant #1 sitting outside in the heat, but confirmed the information was not in her service plan. 2. Record review on 8/27/25 for Tenant #1 revealed the following: a. Progress note, dated 7/11/25, indicated staff reported concerns with Tenant #1's difficulty swallowing medication and increased unsteadiness. The nurse consulted with the primary care provider (PCP) and obtained an order for an occupational therapy/physical therapy and speech therapy (OT/PT/ST) evaluation and treatment. No further information regarding OT/PT/ST evaluation or treatment could be located in the progress notes.	A 360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0008	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE FORT DODGE	1536 20TH AVENUE N FORT DODGE, IA 50501

(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 2 b. Tenant #1's current service plan, dated 6/04/25, revealed no information regarding OT/PT/ST services. During an interview on 8/27/25 at 11:25 a.m., the Registered Nurse (RN) acknowledged Tenant #1 started OT/PT services in July, but the service plan was not revised to include the new services. 2. Record review on 8/27/25 revealed Tenant #2's progress note, dated 6/16/25, indicated he returned from a hospitalization for a pelvic fracture on 6/13/25. According to the progress note, Tenant #2 needed to use a wheelchair instead of his walker because he should have minimal weight bearing in order for the pelvic fracture to heal. Tenant #2's current service plan dated 6/13/25 indicated he used a cane or walker for mobility, with handhold assistance from one person. During an interview on 8/27/25 at 3:05 p.m. the RN confirmed Tenant #2's doctor wanted him to use a wheelchair when he returned to the program after a hospitalization for a pelvic fracture, but the program failed to include this information in the updated service plan.	A 360		
A 420	481-69.27(1)a Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse:	A 420	**A420 Corrective Action Section: Nurse Review Process – 69.27(1)(a)** **Deficiency Cited:** The program failed to complete comprehensive nurse reviews every 90 days or after a significant change, including a review of prescription medications, for three of the three sample tenants (Tenant #1, Tenant #2, and Tenant #4).	

Corrective Action Steps:

1. **Immediate Nurse Reviews for Affected Tenants.**
    - **Responsible Party:** Health and Wellness Director
    - **Timeline:** Within 7 days of this PoC submission
    - **Action:** Complete and document nurse reviews for Tenant #1 and #4, (#2 passed away) including:
        - Review of all prescription medications
        - Verification of current medication orders
        - Written documentation with time, date, and RN signature
        - Divisional Director of Health and Wellness will re-educate the Health and Wellness Director on the requirements related to comprehensive nurse reviews including but not limited to completion every 90 days and with a significant change in condition.
2. **Process Update for Nurse Review Compliance**
    - **Responsible Party:** Health and Wellness

- **Timeline:** Within 7 days of this PoC submission
- **Action:** Process to require:
  - RN-conducted nurse reviews every 90 days
  - Reviews after any significant change in condition, including changes with providers, such as hospice care, podiatry, home health care, occupational therapy, speech, and physical therapy.
  - Medication reconciliation and documentation of interventions/referrals.

3. **Integration with Service Plan and Assessment Process**
   - **Responsible Party:** Health and Wellness Director
   - **Timeline:** Within 7 days of this PoC submission
   - **Action:** Ensure nurse reviews are:
     - Conducted alongside comprehensive assessments
     - Triggered by any significant change in tenant condition
     - Linked to service plan updates and care coordination.
4. **Audit and monitoring of residents' charts.**

			○ **Responsible Party:** Health and Wellness Director and Divisional director of health and wellness. ○ **Timeline:** November7th ,2025. ○ **Action:** The health and wellness director will ensure that all 90-day assessments are completed appropriately. The divisional director of health and wellness will conduct weekly audits of sampled residents' charts and subsequently every 90 days to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0008	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE FORT DODGE	1536 20TH AVENUE N FORT DODGE, IA 50501

(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 420	Continued From page 3 a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders This REQUIREMENT is not met as evidenced by: Based on record review and interview, the program failed to complete comprehensive nurse reviews every 90 days, or after a significant change, which included a review of prescription medications for 3 of 3 sample tenants who resided at the program for over 90 days (Tenant #1, Tenant #2 and Tenant #4). Findings follow: 1. Record review on 8/27/25 revealed Tenant #1's service plan dated 6/04/25, included medication management and assistance with administration. Tenant #1's most recent 90 day nurse review, dated 3/10/25, indicated no changes with Tenant #1's medication information. No additional 90 day nurse review was provided. During an interview on 8/27/25 at 11:25 a.m. the Registered Nurse (RN) confirmed the program failed to complete a review of Tenant #1's medication in the nurse review at least every 90 days. 2. Tenant #1's progress note, dated 7/11/25, indicated staff reported concerns with Tenant #1's difficulty swallowing medication and increased	A 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0008	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE FORT DODGE	1536 20TH AVENUE N FORT DODGE, IA 50501

(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 420	Continued From page 4 unsteadiness. The nurse consulted with the primary care provider (PCP) and obtained an order for an occupational therapy/physical therapy and speech therapy (OT/PT/ST) evaluation and treatment. No further information regarding OT/PT/ST evaluation or treatment could be located in the progress notes. Tenant #1's most recent 90 day nurse review, dated 3/10/25, indicated no changes with Tenant #1's OT/PT/ST. Tenant #1 failed to have a nurse review with the OT/PT/ST referrals and recommendations. During an interview on 8/27/25 at 11:25 a.m., the Registered Nurse (RN) acknowledged Tenant #1 started OT/PT services in July. 3. Record review on 8/27/25 revealed Tenant #2's service plan dated 6/18/25, included medication management and assistance with administration. No nurse review with review of medication could be located in his record. During an interview on 8/27/25 at 3:05 p.m. the RN confirmed the program failed to complete a review of Tenant #2's medication in the nurse review at least every 90 days. 4. Record review on 8/27/25 revealed Tenant #4's service plan, dated 6/16/25, included medication management and assistance with administration. No nurse review with review of medication could be located in her record. During an interview on 8/27/25 at 12:30 p.m. the RN confirmed the program failed to complete a review of Tenant #4's medication in the nurse review at least every 90 days.	A 420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0008	A. BUILDING: _____ B. WING _____	C 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE FORT DODGE	1536 20TH AVENUE N FORT DODGE, IA 50501

(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
