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
	S0029	A. BUILDING: _____ B. WING _____	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE MARION	1100 LINDEN DR MARION, IA 52302

(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. Number of tenants without cognitive impairment: 20 Number of tenants with cognitive impairment: 15 Total census: 35 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification rules for a Dedicated Dementia-Specific Assisted Living Program:	A 000		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medications and treatments as prescribed. This pertained to 1 of 1 tenants reviewed who received insulin and blood glucose monitoring (Tenant #4). Findings follow: 1. Review of Tenant #4's file on 1/7/25 revealed	A 285	The Plan of Correction is attached.	

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an incident report (in Progress Notes) dated 12/13/24 at 9:45 p.m. indicating staff went to her apartment for rounds and found her on the floor foaming from the mouth. Staff called the Health and Wellness Director, turned her on her side and took her blood glucose reading which was 32. The Health and Wellness Director arrived a few minutes later and called 911. Emergency medical services (EMS) arrived and took her to the emergency department (ED).

Continued record review revealed ED records indicated she was admitted on 12/13/24 and discharged on 12/14/24. Final diagnoses included seizure, hypoglycemia, hypothermia, and acute non-recurrent maxillary sinusitis. The records indicated she was found on the floor at the Program actively seizing. It was noted she was likely sweating and laying in wet. She had a blood glucose reading of 46 by EMS and hypothermia of 91 degrees. She was given 250 milliliters (ml) of D10 (Dextrose 10%) by EMS and had a repeat blood glucose of 137. She was awake and alert upon arrival to the ED. Per staff at the Program she did not eat today as she had a cold. She had a blood glucose reading of 166 and received insulin at 5:30 p.m. She was found on the floor seizing at 9:40 p.m. It was noted her seizure was suspected from hypoglycemia. She was prescribed amoxicillin 500 mg, twice daily for 7 days (sinusitis).

The After Visit Summary dated 12/13/24 indicated Tenant #4 was seen in the ED for a seizure from hypoglycemia and she was hypothermic upon arrival. She was given intravenous fluids (IV) and was warmed in the ED. The head computed tomography (CT) showed sinusitis and amoxicillin was ordered. It was noted to increase her threshold to 200 blood glucose for the

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A 285	Continued From page 2 administration of sliding scale insulin. The tenant's primary care provider (PCP) was faxed on 12/17/24 regarding the incident. Orders were confirmed by the PCP to hold Novolog if her blood glucose was 200 or below and continue amoxicillin 500 mg twice daily for the sinus infection. A new order was also received to decrease Lantus to 13 units. Further record revealed Tenant #4's diagnoses included diabetes mellitus type 1 and dementia. The service plan indicated staff administered Tenant #4's medications. Tenant #4 took insulin and had a Dexcom for monitoring her blood glucose. Staff was to monitor for signs and symptoms of hypoglycemia. 2. Review of Tenant #4's December 2024 medication administration records (MARs) indicated orders for Dexcom G6 - test blood glucose 8 times per day (continuous glucometer) scheduled at 2:00 a.m., 5:00 a.m., 8:00 a.m., 11:00 a.m., 2:00 p.m., 5:00 p.m., 8:00 p.m. and 11:00 p.m. She also had an order for Agamatrix - test blood glucose 8 times per day (finger stick) scheduled at the same frequency and schedule listed above. The blood glucose levels documented for 12/13/24 were as follows: - 48 at 2:00 a.m. - 205 at 5:00 a.m. - 195 at 8:00 a.m. - 181 at 11:00 a.m. - 135 at 2:00 p.m. - 161 at 5:00 p.m. Her blood sugars were not documented as taken at 8:00 p.m. as ordered. As noted above on the incident report, her levels taken at 9:45 p.m. that night when found seizing was 32.	A 285		

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A 285	Continued From page 3 The MARs also reflected orders for Novolog Flaxen 100 units/ml solution (9 units subcutaneously every morning with breakfast, 11 units with lunch and 8 units with dinner). Staff initialed the administration of the insulin for the 7:00 a.m. to 9:00 a.m. breakfast time frame, 12:00 p.m. and 5:00 p.m. on 12/23/24. The MARs reflected an order for Novolog Flexpen 100 units/ml solution, three times per day sliding scale. Her sliding orders included the following: - if blood glucose was less than 300, then 0 units were to be administered, - for glucose readings between 300 to 350, 4 units were to be administered - for glucose readings between 351 to 400, 5 units were to be administered. - the PCP was to be called for additional orders for glucose readings over 400. The December MAR reflected on 12/13/24 during the 7:00 to 9:00 a.m. time her blood glucose was 195 and staff documented sliding scale insulin was administered despite the blood glucose levels not being 300 or greater. At 12:00 p.m. her blood glucose was 181 and staff documented insulin was administered despite the blood glucose levels not being 300 or greater. Additionally, sliding scale units were administered in November, December and January and staff initialed for the administration of the medication; however, did not document the number of units of insulin administered based on the blood glucose reading, including on 12/13/24. The tenant's November, December and January MARs revealed an order to administer 1 Trueplus glucose chew 15 minutes as needed (PRN) for	A 285		

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blood glucose readings of less than 60. In December 2024 it was documented as administered on 12/4/24, 12/6/24, 12/11/24, 12/17/24 and 12/18/24. Review of the blood glucose readings indicated Tenant #4 had blood glucose readings less than 60 on 12/2/24, 12/4/24, 12/6/24, 12/11/24, 12/13/24, 12/15/24 and 12/18/24. Glucose chews were not administered on 12/2/24, 12/13/24 or 12/15/24, despite blood glucose readings below 60. Additionally, a chew was documented as administered on 12/17/24; however, none of the recorded blood glucose readings were below 60. In January 2025 it was documented as administered once on 1/3/25. The January 2025 MARs reflected blood glucose readings less than 60 on 1/2/25, 1/3/25 (twice) and 1/5/25. Glucose tablets were not administered on 1/2/25, once on 1/3/25 and 1/5/25, despite blood glucose readings below 60.

The December 2024 and January 2025 MARs also reflected an order for Gvoke Hypo 2 Injection 1 mg/0.2 ml, every day as needed for hypoglycemia. It was not documented as administered as needed in December or January.

3. When interviewed on 1/7/25 at 4:30 p.m. the Health and Wellness Director confirmed the 8:00 p.m. blood glucose check was not documented. She also confirmed all MARs and orders were provided for Tenant #4.

In summary, on 12/13/24 at 9:45 p.m. staff found Tenant #4 on the floor by her bed foaming from the mouth and actively seizing. Her Dexcom indicated low and her blood glucose was 32. EMS was activated and she was taken to the ED. Per ED records she had a blood glucose reading of 46, her body temperature was 91 and she was

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A 285	Continued From page 5 hypothermic. She was administered D10 by EMS. She was treated with IV fluids and warmed in the ED. She was also prescribed an antibiotic for a sinusitis. It indicated in ED records she had been sick and had not eaten. Tenant #4 had ordered blood glucose monitoring eight times per day. On 12/13/24 at 5:00 p.m. her blood glucose reading was 166 and she received 8 units of insulin. On 12/13/24 at 8:00 p.m. there was no recorded blood glucose reading for Tenant #4. This was the most recent scheduled blood glucose reading before she was found on the floor at 9:45 p.m. Her blood glucose monitoring was not completed as ordered. Sliding scale units were documented as administered twice on 12/13/24 despite her blood glucose readings not being greater than 300. Additionally, she had a blood glucose reading of less than 60 on 12/13/24 and several others times in December and January and the Trueplus glucose chews were not administered with blood glucose readings less than 60 as ordered. The sliding scale insulin for November, December and January reflected staff administered the insulin; however, the number of units administered was not recorded, including on 12/13/24. Tenant #4 did not receive her prescribed medications as ordered.	A 285		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed	A 145		

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practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the Program failed to complete evaluations as needed with significant change. This pertained to 2 of 4 tenants reviewed (Tenant #1 and Tenant #3). Findings follow:

1. Review of Tenant #1's file on 1/6/25 revealed a hospital After Visit Summary (AVS) dated 10/28/24 indicating she had a 12 pound weight loss in the past month. Weekly weight checks were ordered for one month and to call with a decrease in weight of 3 pounds or greater.

A Weights document for Tenant #1 indicated a 20 pound weight loss from 9/11/24 to 12/11/24.

Further review revealed evaluations were completed on 10/22/24 post hospitalization; however, evaluations were not completed related to the 20 pound weight loss and new orders as noted above.

2. Review of Tenant #3's file on 1/6/25 and 1/7/25 revealed Progress Notes indicating the following:
- On 10/18/24 a new order was received to increase Cymbalta to 60 milligram (mg) by mouth daily to decrease libido. It indicated to fax the primary care provider (PCP) in two weeks

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regarding an update on sexually inappropriate behavior.
- On 11/6/24 Tenant #3 had an episode where he thought he was in a garage and not at the Program. He was becoming more difficult to redirect.
- On 11/8/24 Tenant #3 was seen related to increased restlessness. A new order was received for a urinalysis (UA) and to increase Mirapex to 0.5 mg, three times daily.
- On 11/12/24 the UA showed growth of pseudomonas fluorescens/putida and a new order was received for ciproflexin 500 mg, by mouth twice daily for 10 days.
- On 11/22/24 Tenant #3 was not sleeping well and was wandering the halls at night and yelling at staff. It was noted he had been very difficult to redirect.
- On 11/26/24 a verbal order was received to start Seroquel 12.5 mg as needed for agitation and to increase Trazodone to 100 mg nightly to help with sleep. Tenant #3 had been up most of the night. He was difficult to redirect overnight, refused a gait belt and had hallucinations in his apartment.
- On 12/5/24 Tenant #3 had come out of his apartment twice during the night without clothing and said he had a guest in his apartment with no one present.
- On 12/5/24 a new order was received for Seroquel 25 mg as needed at bedtime for agitation.
- On 12/7/24 a new order was received to increase Seroquel to 50 mg at bedtime scheduled.
- On 12/8/24 Tenant #3 required the assistance of two staff for transfers that morning.
- On 12/8/24 Tenant #3 required the assistance of two to three staff and was not able to stand.
- On 12/9/24 staff noticed a coffee mug next to

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A 145	Continued From page 8 his chair filled with urine. Staff dumped it out and washed the mug. - On 12/9/24 Tenant #3 required the assistance of two staff with transfers that shift. He could not stand and became verbally aggressive when staff provided assistance with toileting. - On 12/9/24 Tenant #3 had urinated in his continuous positive airway pressure (CPAP) machine. It was cleaned with vinegar. - On 12/10/24 Tenant #3 required the assistance of two staff for transfers that shift. - On 12/12/24 a new order was received to decrease Mirapex to 0.25 mg three times per day due to increased confusion and agitation. - On 12/19/24 it was noted a change of condition was completed for Tenant #3. Continued record review revealed Tenant #3's evaluations were completed on 12/19/24. The evaluations prior were dated 9/30/24. Although evaluations were completed on 12/19/24, evaluations were not completed prior to that when changes occurred related to Tenant #3's behaviors and transfers as noted above. 3. When interviewed on 1/7/25 at 3:50 p.m. the Executive Director confirmed all evaluations requested were provided for the tenants reviewed.	A 145		
A 330	481-69.25(1)q Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the	A 330		

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A 330	Continued From page 9 completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs) This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document routine cares on task sheets pertaining to 1 of 1 tenants reviewed required to have task sheets (Tenant #2). Findings follow: 1. Review of Tenant #2's file on 1/6/25 and 1/7/25 revealed the tenant had Task Sheet-Individualized Resident documents. It indicated it was to be completed for tenants with a Global Deterioration Scale (GDS) of five or greater or who had an outside service provider. Tenant #2 received hospice services and she was staged at a six on the GDS, which indicated severe cognitive decline. Tenant #2's October 2024 task sheets reflected omissions for a.m. cares, p.m. cares, toileting, hygiene and grooming, bathing and night checks. The November 2024 task sheets reflected omissions for a.m. cares, p.m. cares, toileting, and night checks. The December 2024 task sheets reflected omissions for a.m. cares, p.m. cares, toileting, hygiene and grooming, bathing, escorts/mobility and night checks. 2. When interviewed on 1/7/25 at 3:50 p.m. the Executive Director confirmed the individualized task sheets were to be completed for tenants on hospice or if the tenant had a GDS of five. She said the task should be signed off when the care was completed. She confirmed all task sheets requested were provided for Tenant #2.	A 330		

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A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed to reflect the identified needs of the tenants. This pertained to 3 of 4 current tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. Review of Tenant #1's file on 1/6/25 revealed Progress Notes indicating the following: - On 10/2/24 Tenant #1 was seen by a provider for increased depression and increased tearfulness. - On 10/10/24 it was documented Tenant #1 was tearful that afternoon. She was asked to go on a walk and talk. When they reached her apartment and she was asked if she needed to use the bathroom, she became agitated and tearful again. - On 11/12/24 it was documented occupational therapy (OT) would be discharging Tenant #1 next week due to her being at her baseline. Continued record review revealed a hospital After Visit Summary (AVS) dated 10/28/24 indicated	A 350		

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she had a 12 pound weight loss in the past month. Weekly weight checks were ordered for one month and to call with a decrease in weight of 3 pounds or greater.

A Weights document for Tenant #1 indicated a 20 pound weight loss from 9/11/24 to 12/11/24.

Tenant #1's service plan dated reflected she would be working with physical therapy (PT) and OT. The service plan was not updated when Tenant #1 was discharged from OT. The service plan reflected Tenant #1 needed meal reminders or cueing to eat and to encourage hydration but did not reflect her weight loss and new orders. The service plan also did not reflect Tenant #1's tearfulness as noted above.

2. Review of Tenant #2's file on 1/6/25 revealed the tenant received hospice services. The Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated 11/6/24 indicated hospice provided a home health aide to assist with bed baths twice per week.

The tenant's November and December 2024 and January 2025 medication administration records (MARs) reflected staff assisted with applying a lidocaine patch 4%, to the right back rib area every morning and removing it 12 hours later. It was noted to remove the patch at 7:00 p.m. to prevent skin irritation.

Tenant #2's service plan reflected staff assisted with bathing twice weekly. The service plan included Tenant #2 had hospice services; however, did not reflect hospice assisted with her bathing. The service plan reflected staff administered Tenant #2's medications as ordered; however, did not reflect staff assisted with

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A 350	Continued From page 12 applying and removing a lidocaine patch. 3. Review of Tenant #3's file on 1/6/25 and 1/7/25 revealed Progress Notes indicating the following: - On 10/18/24 a new order was received to increase Cymbalta to 60 milligram (mg) by mouth daily to decrease libido. It indicated to fax the primary care provider (PCP) in two weeks regarding an update on sexually inappropriate behavior. - On 11/6/24 Tenant #3 had an episode where he thought he was in a garage and not at the Program. He was becoming more difficult to redirect. - On 11/8/24 Tenant #3 was seen related to increased restlessness. A new order was received for a urinalysis (UA) and to increase Mirapex to 0.5 mg, three times daily. - On 11/12/24 the UA showed growth of pseudomonas fluorescens/putida and a new order was received for ciproflexin 500 mg, by mouth twice daily for 10 days. - On 11/22/24 Tenant #3 was not sleeping well and was wandering the halls at night and yelling at staff. It was noted he had been very difficult to redirect. - On 11/26/24 a verbal order was received to start Seroquel 12.5 mg as needed for agitation and to increase Trazodone to 100 mg nightly to help with sleep. Tenant #3 had been up most of the night. He was difficult to redirect overnight, refused a gait belt and had hallucinations in his apartment. - On 12/5/24 Tenant #3 had come out of his apartment twice during the night without clothing and said he had a guest in his apartment with no one present. - On 12/5/24 a new order was received for Seroquel 25 mg as needed at bedtime for	A 350		

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BICKFORD COTTAGE MARION	1100 LINDEN DR MARION, IA 52302

(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 350	Continued From page 13	A 350		

agitation.
- On 12/7/24 a new order was received to increase Seroquel to 50 mg at bedtime scheduled.
- On 12/8/24 Tenant #3 required the assistance of two staff for transfers that morning.
- On 12/8/24 Tenant #3 required the assistance of two to three staff and was not able to stand.
- On 12/9/24 staff noticed a coffee mug next to his chair filled with urine. Staff dumped it out and washed the mug.
- On 12/9/24 Tenant #3 required the assistance of two staff with transfers that shift. He could not stand and became verbally aggressive when staff provided assistance with toileting.
- On 12/9/24 Tenant #3 had urinated in his continuous positive airway pressure (CPAP) machine. It was cleaned with vinegar.
- On 12/10/24 Tenant #3 required the assistance of two staff for transfers that shift.
- On 12/12/24 a new order was received to decrease Mirapex to 0.25 mg three times per day due to increased confusion and agitation.
- On 12/19/24 it was noted a change of condition was completed for Tenant #3.

Continued record review revealed Tenant #3's service plan was updated on 12/19/24. The service plan prior was dated 9/30/24. The service plan updated on 12/19/24 reflected Tenant #3 used a bedside urinal at night. The service plan did not reflect the behaviors noted above related to urination in the coffee mug or CPAP. The service plan was updated 12/19/24 to reflect he needed the assistance of one with transfers and at times needed the assistance of two with a gait belt due to fatigue. The service plan indicated at times he would inappropriate with staff. Staff would remind him that his comments were not acceptable. The service plan did not reflect all

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A 350	Continued From page 14 behaviors as noted above. 4. When interviewed on 1/7/25 at 3:50 p.m. the Executive Director confirmed all service plans requested were provided for the tenants reviewed.	A 350		
A 460	481-69.28(4) Food Service 69.28(4) Therapeutic diets may be provided by a program. If therapeutic diets are provided, they shall be prescribed by a physician, physician assistant, or advanced registered nurse practitioner. A current copy of the Iowa Simplified Diet Manual published by the Iowa Dietetic Association shall be available and used in the planning and serving of therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and for reviewing procedures for food preparation and service for therapeutic diets. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the Program failed to have a licensed dietitian review procedures for food preparation and service for therapeutic diets. This pertained to 1 of 1 tenant reviewed with a therapeutic diet (Tenant #2). Findings follow: 1. Review of Tenant #2's file on 1/6/25 revealed the service plan indicated Tenant #2 had a mechanical soft diet due to having a history of aspiration pneumonia. The tenant also received hospice services. The Hospice IDG Comprehensive Assessment and Plan of Care	A 460		

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A 460	Continued From page 15 Update Report dated 11/6/24 indicated diagnoses included dysphasia. She had a mechanical soft and ground meat diet with thin liquids. The Meal Order Information sheet dated 6/27/23 indicated a diet change had occurred. Her diagnoses included dementia, recurrent falls, acute respiratory failure with hypoxia and dysphasia. The diet order was for mechanical soft, ground meat. 2. On 1/6/25 at approximately 11:45 a.m. the lunch meal in the memory care unit was observed. The menu for the lunch meal was a red potato beef stew or seasoned catfish fillets, parmesan potatoes, California blend vegetables or spinach with almonds, Hawaiian macaroni salad, a baked roll and ice cream floats. Tenant #2 received the catfish fillets, macaroni salad, vegetables, parmesan potatoes, a dinner roll and ice cream float. The catfish provided to Tenant #2 was not ground and was not cut into small diced pieces. It could not be determined if the catfish had a sauce or liquid to moisten the fish. 3. The menu and recipe sheets for each item Tenant #2 had for lunch on 1/6/25 were provided. The Seasoned Catfish Fillets document indicated for a mechanical soft diet the fish should be 1/8 inch diced pieces and tender cooked. It should be moistened with plenty of sauce that was thick enough (not to let liquid and solids separate). The Hawaiian Macaroni Salad document indicated for mechanical soft diet to omit fresh vegetables, cut tender pasta into 1/8 inch pieces and moisten with extra dressing. The California Blend for the mechanical soft diet indicated the vegetables should be soft well cooked and 1/8 inch diced	A 460		

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A 460	Continued From page 16	A 460		

pieces or mashed. The parmesan potatoes for a mechanical soft diet indicated to remove the skins, the potatoes should be mashed and moistened with gravy, margarine or ketchup. The dinner roll for the mechanical soft diet should be well moistened cut into bite size pieces. It should be moistened with syrup, jelly, margarine or butter.

There was no documented staff training by a dietician provided regarding food preparation and service for therapeutic diets.

4. When interviewed on 1/7/25 at 9:16 a.m. the Bread Basket Manager said the Program had three tenants who received mechanical soft diets, including Tenant #2. He said when an order was received for a diet, the diet order sheet was filled out and kept in the kitchen. He said the Simplified Diet Manual was all online. He said menu approvals were done at corporate and dietician signed off on the all the menus. There had not been a dietician out to the building to go over preparation techniques for therapeutic diets. Regarding the menus items served for lunch on 1/16/25 related to the therapeutic diets, the onions were left out of the macaroni salad but there were shredded carrots, and the salad had extra dressing. The catfish was not cut up when it left the kitchen so it would not get cold. He did not know if was cut up by staff in the unit but said it should have been and they had a pizza cutter to do so. It should have been cut into small diced pieces. There was tarter sauce sent in a separate bowl. For the potatoes, the skin was left off and they were covered in butter. The vegetables were soft and were not served al dente. Rolls were also sent and there was butter. He said fish was the only meat not ground; all other meat was ground. He said staff were aware Tenant #2's

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A 460	Continued From page 17 food needed to be cut. When interviewed on 1/7/25 at 4:30 p.m. the Heath and Wellness Director confirmed three tenants had mechanical soft and ground meat diets, including Tenant #2. She said an order was received from the primary care provider for a diet and she wrote the order on the diet form. It was kept in a binder in the kitchen. The Bread Basket Manager cooked the food and prepared any ground meats. The food was taken to the memory care unit and staff cut the food up into bites. She heard yesterday (1/6/25) Tenant #2's food was not cut up well. When interviewed on 1/7/25 at 3:50 p.m. the Executive Director said there was a dietician involved with menu planning at the branch level. The recipes had therapeutic options at the bottom of each recipe. Everyday, each recipe was printed. She said a dietician came out to complete an inspection (separate from the dietician for the menus). She said a dietician had not come out to review food preparation techniques for therapeutic diets. She confirmed Tenant #2's fish should have been cut into smaller pieces (on 1/6/25) but everything else was okay. They did not grind fish due to temperature issues. Staff were to cut it up.	A 460		
A 510	481-69.28(8) Food Service 69.28(8) All perishable or potentially hazardous food shall be cooked to recommended temperatures and held at safe temperatures of 41°F (5°C) or below, or 135°F (57°C) or above. This REQUIREMENT is not met as evidenced by:	A 510		

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A 510	Continued From page 18 Based on observation, interview, and record review the Program failed to provide foods at required temperatures. This potentially affected all tenants in the memory care unit (census of 7). Findings follow: 1. When observed on 1/7/25 at approximatley 11:35 a.m. Staff A plated and served the meal to the tenants in the memory care unit dining room. She took the temperature of the food prior to serving and recorded the values on the Temperature Log. The values were recorded as the following: - salad 46.9 degrees, - pork chop 166.1 degrees, - turkey cutlet 151.3 degrees, - stewed tomatoes 126.7 degrees, - squash 149.0 degrees Staff A was not observed sanitizing the thermometer between food items. The salad (cold food) was served at 46.9 degrees, which was greater than the safe temperature of 41 degrees. The stewed tomatoes (hot food) was served at 126.7 degrees, which was below the required temperature of 135 degrees. 2. On 1/7/25 review of the food temperatures for the memory care unit from 1/1/25 to 1/6/25 revealed the following items out of compliance related to food temperatures: - On 1/1/25 for breakfast sausage, gravy and biscuits was served at 132.5 degrees and fresh fruit was served at 43.2 degrees. - On 1/1/25 for lunch mandarin oranges were served at 46.5 degrees and sauteed vegetables were served at 133.8 degrees. - On 1/2/25 for breakfast hot cereal was served at 113.9 degrees and fresh fruit was served at 46.5 degrees.	A 510		

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A 510	Continued From page 19 - On 1/2/25 for lunch a Caesar salad was served at 53.8 degrees and a vanilla pudding dessert was served at 60 degrees. - On 1/3/25 for lunch a Jello salad was served at 58.1 degrees and macaroni and cheese was served at 115.8 degrees. - On 1/4/25 for breakfast fresh fruit was served at 43.0 degrees. - On 1/4/25 for dinner a hot turkey sandwich was served at 131.4 degrees. - On 1/5/25 for dinner a fruit medley was served at 42.8 degrees. - On 1/6/25 for dinner a pasta salad was served at 46.0 degrees and vanilla pudding at 45.8 degrees. 3. When interviewed on 1/7/25 at 3:50 p.m. the Executive Director said hot foods should be served at 140 degrees or greater and cold foods less than 41 degrees. She said the temperature of the food was taken in the main kitchen to ensure it was ready prior to taking the food to the memory care unit. Staff in the memory care unit took the temperature of the food prior to serving. She confirmed all food temperatures requested were provided.	A 510		

Plan of Correction - Bickford Cottage Marion

A 285 481-67.5(2)f(4) Medications

Regulatory Insufficiency:

The program failed to administer medications and treatments as prescribed.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenants # 1 continues to reside in the community and receives medications per physician orders.

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

- The Divisional Director of Health & Wellness will provide re-education on 2/27/25 to the HWD on the Medication Administration Policy.
- The HWD or designee will provide education to Medication Aides and/or Medication Managers on Medication Administration Policy on 2/27/25. Those medication aides and/or medication mangers who are not in attendance shall be provided 1:1 education.
- The HWD or designee will provide education to new medication aides and/or mangers upon hire, on the Medication Administration Policy.

The program will monitor performance to ensure compliance as follows:

- HWD or designee will review Medication Administration Record reports weekly for 90 days to ensure medications are given per physician order. HWD will follow up with staff if any medications are not administered per physician order to determine cause and corrective action.
- The Divisional Director of Health & Wellness will review Medication Administration Records twice per year and as needed during onsite visits to ensure that policy implementation is compliant.

Date deficiencies corrected by: 2/28/2025

A 145 481-69.22(3) Evaluation of Tenant

Regulatory Insufficiency:

The program failed to complete evaluations as needed with significant change.

Plan of Correction:

The insufficiencies will be corrected as follows:

- The program will provide an evaluation of a tenant when significant changes occur.

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

- Tenant #1 continues to reside in the program. HWD completed re-evaluations on 2/19/25.
- Tenant #3 continues to reside in the program. HWD completed re-evaluations on 2/27/25.
- Divisional Director of Health & Wellness or designee to provide HWD education on Assessment Policy and Service Planning and Agreements Policy on 2/27/25.

The program will monitor performance to ensure compliance as follows:

- The HWD or designee will review EHR documentation during each business day to ensure evaluations are completed per policy.
- The Divisional Director of Health & Wellness or designee will audit tenant records to ensure policy implementation is compliant.

Date deficiencies corrected by: 2/28/2025

A 330 481-69.25(1)q Tenant Documents

Regulatory Insufficiency:

The program failed to document routine cares on individualized task sheets.

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

- Tenant #2's individualized task sheet was reviewed and updated on 2/27/25 to reflect routine personal and health related care.

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

- The Divisional Director of Health & Wellness will review state regulation 69.25(1)q with HWD on 2/27/25.
- HWD will provide education to staff on 2/28/25 on individualized task sheets.

The program will monitor performance to ensure compliance as follows:

- HWD will audit individualized task sheets weekly for completion x 90 days and as needed.
- The Divisional Director of Health & Wellness will monitor individualized task sheets for completion during onsite visits twice yearly and as needed.

Date of deficiencies corrected by: 2/28/25

A 350 481-69.26(1) Service Plans

Regulatory Insufficiency:

The program failed to update service plans as needed to reflect the identified needs of the tenants.

Plan of Correction:

The insufficiencies will be corrected as follows:

- HWD performed a Nursing Assessment, Cognitive Assessment, Service Assessment and Service Plan for Tenant # 1 on 2/19/25. HWD directs/delegates resident care per physician order.
- HWD performed a Nursing Assessment, Cognitive Assessment, Service Assessment and Service Plan for Tenant # 2 on 1/13/25. HWD directs/delegates resident care per physician order.
- HWD performed a Nursing Assessment, Cognitive Assessment, Service Assessment and Service Plan for Tenant # 3 on 2/27/25. HWD directs/delegates resident care per physician order.

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

- The Divisional Director of Health & Wellness provided re-education to the HWD on Service Planning and Agreement Policy on 2/27/25.
- HWD will review EHR and observe residents for significant changes to initiate evaluations and Service Plan updates to meet tenants' individual needs and preferences for care.

The program will monitor performance to ensure compliance as follows:

- The Divisional Director of Health & Wellness or designee will audit resident records at least twice per year during onsite visits and as needed to ensure resident Service Plans reflect identified needs of the tenants.

Date deficiencies corrected by: 2/28/25

A 460 481-69.28(4) Food Service

Regulatory Insufficiency:

The program failed to have a licensed dietician review procedures for food preparation and service for therapeutic diets.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Education has been provided for all caregivers and kitchen staff for Tenant #2 and all therapeutic diets currently in use.

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

- Quarterly education will be provided on therapeutic diets by a registered dietitian.
- HWD, Executive Director, Breadbasket Manager, or designee will provide quarterly training to all caregivers and prn as tenant diets are updated.

The program will monitor performance to ensure compliance as follows:

- The Executive Director will review preparation and serving of therapeutic diets 2x monthly for each meal and prn.

Date deficiencies corrected by: 2/28/25

A 510 481-69.28(8) Food Service

Regulatory Insufficiency:

The program failed to provide food at required temperatures.

Plan of Correction:

The insufficiencies will be corrected as follows:

- The program will temp all foods before leaving the kitchen to memory care.
- All hot food will be placed in the heating element to keep food at 135F or above.
- Cold food will be placed in the fridge to keep food at 41F or lower.
- Before serving food in memory care, caregivers will temp all food items.

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

- Executive Director/Breadbasket Manager or designee to provide food safety training upon hire, annually, and prn. This training was provided for all caregivers and kitchen staff on 1/15/25.
- Executive Director/Breadbasket Manager or designee to provide food safety training for all employees on 2/26/25.
- Executive Director/Breadbasket Manager or designee to replace all thermometers to ensure accurate food temps in all areas of the community.

The program will monitor performance to ensure compliance as follows:

- Executive Director/Breadbasket Manager or designee to review food temps daily to ensure compliance with safe food temps and proper probe sanitization for 90 days and prn thereafter.

Date deficiencies corrected by: 2/28/25