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 _____	C 06/04/2024

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: 22 Number of tenants with cognitive impairment: 13 Total census: 35 Complaint #116237-C was investigated and the following regulatory insufficiencies were identified:	A 000		
A 125	481-67.2(1)d Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: d. The incident report shall include statements from individuals, if any, who witnessed the incident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have a policy and procedure regarding incident reports that had all required information. On 6/3/24 review of the Program's Incident and Accident Report policy and procedure indicated all incidents and accidents were to be documented in the Electronic Health Record	A 125	The Plan of Correction is attached	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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 _____	C 06/04/2024

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 125	Continued From page 1 immediately after the occurrence. The person in charge at the time of the incident or accident would prepare or sign the report. The policy did not indicate the incident report would include statements from individuals if the incident was witnessed. When interviewed on 6/4/24 at 10:02 a.m. the Executive Director confirmed all policies and procedures were provided.	A 125		
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: Based on interview and record review the Program failed to follow their policy and procedure related to the completion of incident reports. This pertained to 1 of 3 tenants reviewed (Tenant #2). Findings follow: Review of Tenant #2's file on 5/30/24 and 6/3/24 revealed a Progress Note dated 1/10/24 indicating the tenant was sexually inappropriate over the weekend. He was told to stop masturbating in the common area; however, he just turned away from staff and continued. It was also noted he grabbed another tenant's hands in a rough manner and pulled her toward him. Incident reports related to the behaviors noted above could not be located. When interviewed on 6/4/24 at 10:02 a.m. the	A 150		

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 _____	C 06/04/2024

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 150	Continued From page 2 Executive Director confirmed all incident reports for the tenant were provided.	A 150		
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure 1 of 3 tenants reviewed was treated with consideration, respect and full recognition of personal dignity and autonomy (Tenant #1). Findings follow: When interviewed on 5/30/24 at 9:38 a.m. and 6/3/24 at 2:46 p.m. Staff B said Tenant #1's apartment was generally locked every day as he could not be alone because he sometimes tried to stand up. He was allowed to rest and was not restricted from the apartment if requested. His door was propped open if wanted to rest in bed. He usually spent his time in the common areas. The tenant did not spend much time in the apartment and did not ask to nap. He did not have a key to his apartment but staff would unlock the door if he requested them to. On 6/3/24 at 3:25 p.m. Staff F said Tenant #1's apartment had been kept locked in the past. She did not think it had been locked lately. He had tried to go into the bathroom in his apartment on	A 155		

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 _____	C 06/04/2024

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 155	Continued From page 3 his own. It depended on how well staff could watch him (related to if the door was locked). She said he had access to his apartment. Review of Tenant #2's file on 5/30/24 and 6/3/24 revealed he was staged at a five on the GDS (cognitive evaluation) which indicated moderately severe cognitive decline. His diagnoses included dementia and Parkinson's disease. His service plan dated 5/21/24 reflected Tenant #2 required the assistance of one to two people for transfers and he usually stayed in his wheelchair due to unsteadiness. When interviewed on 6/4/24 at 10:02 a.m. the Executive Director said she was not aware of Tenant #2's door being locked and it was not directed by leadership staff to lock his door. She confirmed Tenant #2 did not have a key to his apartment. When interviewed on 6/4/24 at 11:05 a.m. the Health and Wellness Director said staff had not been directed by leadership staff to lock Tenant #2's apartment door. It should not be locked and it was inappropriate to lock it. She confirmed he did not have the key to his apartment.	A 155		
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		

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 _____	C 06/04/2024

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 145	Continued From page 4	A 145		

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 3 tenants reviewed (Tenant #1 and Tenant #2). Findings follow:

1. Review of Tenant #1's record on 5/30/24 and 6/4/24 revealed a Resident Assessment (functional evaluation) dated 5/7/24 related to change in condition. Cognitive and health evaluations were not completed with significant change as required. A Resident Assessment (functional evaluation) was completed on 5/29/24 for a change of condition. The Global Deterioration Scale (cognitive evaluation) was completed on 5/29/24. A health evaluation was not completed with significant change as required.

Tenant #1 moved in to an apartment in the general population area of the Program on 2/8/23. Tenant #1 moved to an apartment in the dementia unit on 5/29/24. Progress notes indicated the following:
- On 11/16/23 it was noted the previous day staff escorted Tenant #1 to the dementia unit for lower stimulation. Staff went to shake Tenant #1's hand and he squeezed her hand and twisted. When staff released her hand, he raised his fist at her,

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 _____	C 06/04/2024

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 145	Continued From page 5	A 145		

said he hated her and then pushed staff. Another staff observed and tried to separate Tenant #1 from the staff and he pushed that staff. He noticed another staff in the unit, walked toward her and yelled. He saw another staff and tried to hit her. The nurse responded to de-escalate and brought him to the general population to walk around.

- On 11/16/23 Tenant #1 woke up at 4:00 a.m. and walked around. He attempted to tear up a box for items for a charity. Staff intervened and explained what it was for and attempted to take the box back. He started to walk away and then turned back, grabbed the staff by the arms and shoved the staff. Staff attempted to give an as needed medication but it was unsuccessful.
- On 11/20/23 Tenant #1 attempted to go into the kitchen door and staff attempted redirection. Tenant #1 put both hands on the staff's chest and pushed her.
- On 12/14/23 Tenant #1 was very agitated with staff, tried to shove staff, hit staff several times and was very aggressive.
- On 12/15/23 at about 4:00 p.m. Tenant #1 was agitated after staff provided redirection related to their belongings. Tenant #1 refused to give the belongings back, he used profanity towards staff and told him he would hit him. He started to push and shove staff across the room. Another staff intervened and he punched that staff in the stomach.
- On 12/15/23 at about 4:30 p.m. staff attempted to help and encourage Tenant #1 to eat and he became agitated and staff walked away. Tenant #1 followed staff into another tenant's apartment and staff attempted to redirect Tenant #1 to the main area. He punched staff in the stomach.
- On 1/18/24 Tenant #1 was seen hovering over another tenant's food. Staff showed Tenant #1 where his food was located. He then punched

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 _____	C 06/04/2024

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 145	Continued From page 6	A 145		

staff in the stomach.
- On 1/20/24 staff attempted to give a medication as scheduled and he punched the staff five times in various locations on her body. Staff called for help and another intervened.
- On 1/24/24 it was noted Tenant #1 was getting into dirty dishes in the sink and staff asked him to put down a bowl and he refused. Staff was afraid he would throw it and break it. When staff tried to take it, he punched her in the ribs.
- On 1/27/24 Tenant #1 was wandering the halls and grabbed staff's hand twisted it and then pushed her against a pillar.
- On 2/3/24 it was noted Tenant #1 was "day staying" in the dementia unit for lower stimulation and it had helped with some of his behaviors.
- On 2/11/24 During the 3:00 p.m. to 11:00 p.m. on the dementia unit during the shift Tenant #1 was awake and active in the dementia unit until he fell asleep in the chair at 8:00 p.m.
- On 2/12/24 it was noted he was sitting on the couch in the dementia unit visiting with his family member. Shortly after he closed his eyes and napped for a while. He got up for the meal and was awake and walking around in the dementia unit until 7:00 p.m. to 8:00 p.m. when he fell asleep in the chair. A staff member came and took him back to his apartment to get ready for bed.
- On 2/13/24 it was noted Tenant #1 was napping on the couch (dementia unit) when staff arrived. He woke up, ate dinner and walked the halls. He sat down and listened to music before taking his medications and staff brought him to bed.
- On 2/13/24 Tenant #1 became verbal with another tenant and moved to hit her, which did not occur. He also swung at staff as she walked by but did not make contact.
- On 3/1/24 staff attempted to wipe off his hands

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 _____	C 06/04/2024

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 145	Continued From page 7	A 145		

and he squeezed staff's hands and then pushed her. Another staff intervened and stopped him from pushing her down.
- On 3/15/24 it was noted staff gave Tenant #1 a hug, he pushed her and she walked away. He followed her and slapped her.

Evaluations related to significant changes of moving the tenant to the dementia unit during awake hours as well as verbal and physical aggession as noted above could not be located.

2. Reivew of Tenant #2's file on 5/30/24 and 6/4/24 revealed a Resident Assessment (functional evaluation) dated 12/13/23 for a change of condition. A GDS (cognitive evaluation) was also completed; however, a health evaluation was not completed with the significant change.

Continued record review revealed Fax Coversheets indicating the following:
- On 12/8/23 it was noted an order was received for anti-embolism hose due to bilateral lower extremity swelling.
- On 1/18/24 it was noted an order was received to change Tenant #2's diet to a mechanical soft diet with ground meat due to coughing a lot at meals.
- On 3/22/24 it was noted an order was received for physical therapy (PT), as Tenant #2 was becoming a two person assist with transfers.

When interviewed on 6/3/24 at 2:46 p.m. Staff B said Tenant #2 typically required two staff to assist with transfers. Staff used a gait belt and he worked with PT. She said typically he required the assistance of one person when transferred from the wheelchair to toilet and he grabbed the bar.

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 _____	C 06/04/2024

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 145	Continued From page 8 When interviewed on 5/30/24 at 3:58 p.m. Staff C said Tenant #2 required the assistance of two people for transfers on her shift. She said she always used two staff for transfers with Tenant #2, although some people could assist him by themselves. When interviewed on 6/3/24 at 3:25 p.m. Staff F said she had always used two staff to assist Tenant #2 with transfers. Sometimes she tried to get a third staff. When interviewed on 6/3/24 at 2:58 p.m. Staff G said Tenant #2 required the assistance of two staff and at times a third staff. Staff used a gait belt. She said from chair to chair he required the assistance of two people 80 to 85%. At times he was able to transfer from wheelchair to toilet with one person assisting and he would use the grab bar. When interviewed on 6/4/24 at 11:05 a.m. the Health and Wellness Director said Tenant #2 had required the assistance of two staff for transfers and it had been getting harder. When interviewed on 6/4/24 at 10:02 a.m. the Executive Director said Tenant #2 had required the assistance of two people for transfers for a few months. Evaluations could not be located with new orders for anti-embolism hose, a change in diet to mechanical soft with ground meats, PT and a change in transfers related to Tenant #2 requiring the assistance of two people for transfers. 3. When interviewed on 6/4/24 at 10:02 a.m. the Executive Director confirmed all evaluations were provided for tenants reviewed.	A 145		

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 _____	C 06/04/2024

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 155	481-69.23(1)b Criteria for Admission / Retention of Tenants 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: b. Requires routine, two-person assistance with standing, transfer or evacuation This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to discharge a tenant who exceeded retention criteria. This pertained to 1 of 3 tenants reviewed (Tenant #2). Findings follow: 1. When observed on 5/30/24 at 4:30 p.m. Staff C and Staff E assisted Tenant #2 to transfer. Staff put the wheelchair pedals on his chair. Staff E pushed the wheelchair over to the dining room table. There was a dining room chair located near the table where a gait belt was located. Staff C and Staff E placed the gait belt on Tenant #2 prior to the transfer. His walker was placed in front of him and the table. Both staff assisted to transfer him, one on each side. The tenant stood with his walker and pivot transferred to the dining room chair. On 6/3/24 at 11:45 a.m. Staff B and Staff G assisted Tenant #2 to transfer from his wheelchair to the dining room table. Staff B and Staff G put on a gait belt. Tenant #2 pushed up using the arms of the chair and stood up with his walker in front of him. There was one staff on each side of him. Staff prompted him to turn and he went to sit down initially without the chair behind him. Staff	A 155		

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 _____	C 06/04/2024

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 155	Continued From page 10 was able to assist him safely to a seated position in the chair. 2. When interviewed on 6/3/24 at 2:46 p.m. Staff B said Tenant #2 typically required two staff to assist with transfers. Staff used a gait belt and he worked with physical therapy (PT). She said typically he required the assistance of one person when transferred from the wheelchair to the toilet and he grabbed the bar. On 5/30/24 at 3:58 p.m. Staff C said Tenant #2 required the assistance of two people for transfers on her shift. She said she always used two staff for transfers with Tenant #2, although some people could transfer him by themselves. When interviewed on 5/30/24 at 4:50 p.m. Staff E said Tenant #2 was a lot more mobile on first shift. He required the assistance of two people 50% or more of the time on her shift. During an interview on 6/3/24 at 3:25 p.m. Staff F said she had always used two staff to assist Tenant #2 with transfers. Sometimes she tried to get a third staff. When interviewed on 6/3/24 at 2:58 p.m. Staff G said Tenant #2 required the assistance of two staff and at times a third. Staff used a gait belt. She said from chair to chair he required the assistance of two people 80 to 85%. At times he was able to transfer from wheelchair to toilet with one person assisting and he would use the grab bar. On 6/4/24 at 11:05 a.m. the Health and Wellness Director said Tenant #2 required the assistance of two staff for transfers and it had been becoming harder. The primary care provider (PCP)	A 155		

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 _____	C 06/04/2024

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 155	Continued From page 11	A 155		

indicated Tenant #2 needed a higher level of care. He had required the routine assistance of two staff for two to three months. She said the corporate office had been made aware. She had transferred the tenant about three weeks prior on second shift and he required the assistance of two staff. He stood and pivot transferred to the wheelchair. He had worked with PT previously and was currently working with a different PT agency.

When interviewed on 6/4/24 at 10:02 a.m. the Executive Director said Tenant #2 had required the assistance of two people for transfers for a few months. He had worked with PT once and then another PT company was tried. There had been communication with the corporate office about Tenant #2's level of care. A 30 day notice of transfer had not been given to Tenant #2 as it had to be approved.

3. Review of Tenant #2's file on 5/30/24 and 6/3/24 revealed diagnoses including dementia and Parkinson's disease. Tenant #2 was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. He resided in the dementia unit.

Progress Notes indicated the following:
- On 11/14/23 it was noted Tenant #2 required the assistance of two staff for transfers during the shift. Tenant #2 said he was too tired to stand up. Staff would start to use a gait belt for safety and it was discussed with Tenant #2's spouse regarding getting a hospital bed for an easier transfer.
- On 3/12/24 it was noted Tenant #2 had Parkinson's disease and had difficulty with ambulation.
- On 3/25/24 a new order was received for PT due to Tenant #2 requiring the assistance of two

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 _____	C 06/04/2024

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 155	Continued From page 12	A 155		

people for transfers more than 50% of the time.
- On 4/3/24 it was noted Tenant #2 required the assistance of two people for transfers from sitting to standing at all times. PT was was working with him. An addendum indicated PT reported Tenant #2 required the assistance of two people for transfers but they would continue to work with him.
- On 4/9/24 it was noted Tenant #2 required the assistance of two to three staff for transfers at all times.
- On 4/21/24 Tenant #2 required the assistance of two staff for transfers for toileting. Tenant #2 was not able to stand or walk today.
- On 4/23/24 Tenant #2 required the assistance of two staff for transfers today.
- On 5/7/24 Tenant #2 struggled to stand and it was difficult for him to move his leg. He required the assistance of three staff for p.m. cares.
- On 5/21/24 (90 day review) it was noted Tenant #2 required the assistance of one to two people, with a gait belt and walker. He used his wheelchair most of the time. He had five falls in the past 180 days. Tenant #2 worked with PT.

A Long Term Care Facility Visit document with an encounter date of 5/13/24 revealed Tenant #2 was seen at the Program by his PCP. It was noted he continued to have frequent falls. He required the assistance of two people for transfers. He required the assistance of three to four people to transfer after he has fallen. PT had been working with Tenant #2, but he was not making any progress related to the number of people needed for his transfers. The PCP indicated he would benefit from a higher level of care. The document indicated he "consistently requires 2 people for transfers, in need of higher level of care."

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 _____	C 06/04/2024

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 155	Continued From page 13 A PT document dated 4/4/24 indicated Tenant #2 needed the assistance of two people for transfers. For assistive devices he used a walker, gait belt and wheelchair. Evaluations were completed on 5/21/24 and the service plan was developed dated 5/21/24. The service plan indicated he was an assist of one or two for transfers with his walker. It indicated Tenant #2 mostly stayed in his wheelchair as he was unsteady. 4. On 6/4/24 review of the Program's Admission Agreement revealed the agreement would be terminated if a tenant required a routine two-person assist with standing, transfers, evacuation. 5. When interviewed on 6/4/24 at 10:02 a.m. the Executive Director confirmed Tenant #2 required the assistance of two people for transfers routinely.	A 155		
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	A 350		

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 _____	C 06/04/2024

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 350	Continued From page 14	A 350		

by:
Based on interview and record review the Program failed to update service plans as needed. This pertained to 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow:

1. Review of Tenant #1's record on 5/30/24 and 6/4/24 revealed service plans dated 5/7/24 and 5/29/24. The service plans were not based on evaluations on 5/7/24 as only a functional evaluation was completed. On 5/29/24 functional and cognitive evaluations were completed; however, a health evaluation was not completed.

Tenant #1 was admitted to an apartment in the general population area of the Program on 2/8/23. Tenant #1 moved to an apartment in the dementia unit on 5/29/24. Progress Notes indicated the following:
- On 11/16/23 it was noted the day prior staff escorted Tenant #1 to the dementia unit for lower stimulation. Staff went to shake Tenant #1's hand and he squeezed her hand and twisted. When staff released her hand, he raised his fist at her, said he hated her and then pushed staff. Another staff observed and tried to separate Tenant #1 from the staff and he pushed that staff. He noticed another staff in the unit, walked toward her and yelled. He saw another staff and tried to hit her. The nurse responded to de-escalate and brought him to the general population to walk around.
- On 11/16/23 Tenant #1 woke up at 4:00 a.m. and walked around. He attempted to tear up a box for items for a charity. Staff intervened and explained what it was for and attempted to take the box back. He started to walk away and then turned back, grabbed the staff by the arms and shoved the staff. Staff attempted to give an as needed medication but it was unsuccessful.

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 _____	C 06/04/2024

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 350	Continued From page 15	A 350		

- On 11/20/23 Tenant #1 attempted to go into the kitchen door and staff attempted redirection. Tenant #1 put both hands on the staff's chest and pushed her.
- On 12/14/23 Tenant #1 was very agitated with staff, tried to shove staff, hit staff several times and was very aggressive.
- On 12/15/23 at about 4:00 p.m. Tenant #1 was agitated after staff provided redirection related to their belongings. Tenant #1 refused to give the belongings back, he used profanity towards staff and told him he would hit him. He started to push and shove staff across the room. Another staff intervened and he punched that staff in the stomach.
- On 12/15/23 at about 4:30 p.m. staff attempted to help and encourage Tenant #1 to eat and he became agitated and staff walked away. Tenant #1 followed staff into another tenant's apartment and staff attempted to redirect Tenant #1 to the main area. He punched staff in the stomach.
- On 1/18/24 Tenant #1 was seen hovering over another tenant's food. Staff showed Tenant #1 where his food was located. He then punched staff in the stomach.
- On 1/20/24 staff attempted to give a medication as scheduled and he punched the staff five times in various locations on her body. Staff called for help and another intervened.
- On 1/24/24 it was noted Tenant #1 was getting into dirty dishes in the sink and staff asked him to put down a bowl and he refused. Staff was afraid he would throw it and break it. When staff tried to take it, he punched her in the ribs.
- On 1/27/24 Tenant #1 was wandering the halls and grabbed staff's hand twisted it and then pushed her against a pillar.
- On 2/13/24 Tenant #1 became verbal with another tenant and moved to hit her, which did not occur. He also swung at staff as she walked

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 _____	C 06/04/2024

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 350	Continued From page 16	A 350		

by but did not make contact.
- On 3/1/24 staff attempted to wipe off his hands and he squeezed staff's hands and then pushed her. Another staff intervened and stopped him from pushing her down.
- On 3/15/24 it was noted staff gave Tenant #1 a hug, he pushed her and she walked away. He followed her and slapped her.

Further review revealed a service plan dated 10/9/23 reflected he ate one meal (supper) in the dementia unit to help with sundowning. A service plan 11/21/23 reflected Tenant #1 ate his meals in the dementia unit to prevent over stimulation. He was assisted with toileting 45 minutes prior to going back to the dementia unit for his meals. A service plan dated 5/7/24 indicated Tenant #1 "day stays" in the dementia unit to avoid over-stimulation. The service plan was not updated when Tenant #1 began spending days in the dementia unit months prior. Additionally the service plan dated 5/7/24 reflected he demonstrated verbal and physically disruptive behaviors. It did not reflect the extent of his behaviors. It indicated he could have behaviors when over-stimulated. If he was having a difficult day staff was to call his family. There was no service plan update between November 2023 and March 2024 when he displayed multiple episodes of aggression towards staff.

2. Review of Tenant #2's file on 5/30/24 and 6/4/24 revealed a Progress Note dated 7/28/23 indicating Tenant #2's family requested his mattress be placed on the floor due to falls and because he liked a harder surface. The service plan dated 7/28/23 reflected Tenant #2 was a high fall risk and he liked to sleep on the floor and the mattress would be put on the floor for his safety and comfort. The service plan was updated

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 _____	C 06/04/2024

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 350	Continued From page 17 on 10/9/23 but did not reflect the mattress and sleep arrangements for Tenant #2. When interviewed on 5/29/24 at 4:02 p.m. Staff A said Tenant #2's apartment had a urine odor and he used to urinate on the floor. When interviewed on 6/4/24 at 11:05 a.m. the Health and Wellness Director said the carpet in Tenant #2's apartment was cleaned every two to three months. It had odors as he had been urinating on the floor on third shift. When interviewed on 6/4/24 at 10:02 a.m. the Executive Director said Tenant #2's apartment was cleaned almost monthly and in between was spot cleaned by staff. She said Tenant #2 urinated on the carpet at night and the carpet in his apartment had a urine odor. Further review revealed Fax Coversheets indicating the following: - On 12/8/23 an order was received for anti-embolism hose due to bilateral lower extremity swelling. - On 1/18/24 an order was received to change Tenant #2's diet to a mechanical soft diet with ground meat due to coughing a lot at meals. - On 3/22/24 an order was received for physical therapy (PT), as Tenant #2 was becoming a two person assist with transfers. When interviewed on 6/3/24 at 2:46 p.m. Staff B said Tenant #2 typically required two staff to assist with transfers. Staff used a gait belt and he worked with physical therapy (PT). She said typically he required the assistance of one person when transferred from the wheelchair to the toilet and he grabbed the bar.	A 350		

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 _____	C 06/04/2024

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 350	Continued From page 18	A 350		

On 5/30/24 at 3:58 p.m. Staff C said Tenant #2 required the assistance of two people for transfers on her shift. She said she always used two staff for transfers with Tenant #2, although some people could transfer him by themselves.

When interviewed on 5/30/24 at 4:50 p.m. Staff E said Tenant #2 was a lot more mobile on first shift. He required the assistance of two people 50% or more of the time on her shift.

During an interview on 6/3/24 at 3:25 p.m. Staff F said she had always used two staff to assist Tenant #2 with transfers. Sometimes she tried to get a third staff.

When interviewed on 6/3/24 at 2:58 p.m. Staff G said Tenant #2 required the assistance of two staff and at times a third. Staff used a gait belt. She said from chair to chair he required the assistance of two people 80 to 85%. At times he was able to transfer from wheelchair to toilet with one person assisting and he would use the grab bar.

On 6/4/24 at 11:05 a.m. the Health and Wellness Director said Tenant #2 required the assistance of two staff for transfers and it had been becoming harder.

When interviewed on 6/4/24 at 10:02 a.m. the Executive Director said Tenant #2 had required the assistance of two people for transfers for a few months.

Tenant #2's service plan dated 5/21/24 did not reflect the issue of urinating on the floor on third shift as indicated in staff interviews. It reflected Tenant #2 had a mechanical diet; however, the change in diet occurred in January 2024. The

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 _____	C 06/04/2024

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 350	Continued From page 19 service plan was not updated when the change occurred. Additionally, the service plan was not updated as needed to reflect the anti-embolism hose. The service plan stated the tenant required the assistance of one to two people for transfers and that he was working with PT. The service plan did not reflect he routinely required the assistance of two people for transfers. 3. Review of Tenant #3's file on 6/3/24 revealed Progress Notes indicating the following: - On 4/15/24 a new order was received for Calmoseptine due to redness to her buttocks. - On 4/24/24 Tenant #3's family requested to discontinue PT. Tenant #3's May 2024 medication administration record (MAR) reflected an order for Calmoseptine ointment to be applied topically to buttocks twice daily for redness until healed. The MAR reflected staff initialed the task was completed twice daily. The tenant's service plan dated 4/26/24 reflected PT services despite PT being discontinued and did not reflect the reddened area on Tenant #3's buttocks and ordered treatment. 4. When interviewed on 6/4/24 at 10:02 a.m. the Executive Director confirmed all service plans for the tenants reviewed were provided.	A 350		
A 710	481-69.35(1)b Structural Requirements 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary.	A 710		

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 _____	C 06/04/2024

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 710	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to maintain a well-maintained, clean and safe building. This potentially affected all tenants (census of 35). Findings follow: 1. When observed on 5/29/24 at approximatley 2:30 p.m. and 5/30/24 at approximately 2:05 p.m. it was noted there was a large stain on the carpet near Tenant #2's bed in his apartment. The carpeting in the dementia unit in various areas of the common area was heavily stained. This included the hallway outside of the kitchen area, the living area, and the entrance to the unit. Observation on 5/30/24 at approximately 2:05 p.m. revealed an area outside of the medication room and office, near the dining room of the general population side of the building, was also heavily stained. Observation on 6/4/24 at approximately 11:40 a.m. revealed the carpet near the living room and dining room area was frayed. There was an area of the carpet that appeared to be separated and had a piece of carpeting wedged in between. It was located near the living area located in a main hallway to the common area. The area of the medication room and office near the dining were again observed and were heavily stained. 2. On 6/4/24 review of an Unusual Occurrence Report dated 6/27/23 indicated Tenant #4 fell in the common sitting area. Tenant #4 lost his balance, fell backwards and hit his head. Staff were near and heard him fall. The report indicated the cause of the occurrence was lost balance and a carpet tear. The incident report	A 710		

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 _____	C 06/04/2024

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 710	Continued From page 21	A 710		

noted branch support (corporate) was notified of the fall and carpet tear.

Continued record review revealed General Ledger Reports indicated carpet cleaning (common areas):
- Completed carpet cleaning on 12/15/22 (posted 1/15/23)
- Completed carpet cleaning on 5/2/23 (posted date 5/2/23)
- Completed carpet cleaning on 9/7/23 (posted date 9/15/23).

Further record review revealed a General Ledger Report and invoices reflected carpet cleaning was completed in Tenant #2's apartment on 11/30/23 and 2/29/24.

3. When interviewed on 5/29/24 at 4:02 p.m. Staff A said there were stains on the carpet, including in the dementia unit. She also said Tenant #2's apartment had a urine odor and she said he used to urinate on the floor.

On 6/3/24 at 2:58 p.m. Staff G said Tenant #2's apartment had a urine odor at times.

When interviewed on 6/4/24 at 11:05 a.m. the Health and Wellness Director said the carpeting in the common areas were cleaned about every 90 days and Tenant #2 had the carpet cleaned in apartment every two to three months. It had odors as he had been urinating on the floor on third shift. She said all the carpeting in the dementia unit in the high traffic areas needed replaced. It was been brought up to corporate. She said there was also fraying of the carpet and it constantly frayed. There was a fall related to one spot of the carpet with Tenant #4 (see incident report above).

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 _____	C 06/04/2024

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 710	Continued From page 22 When interviewed on 6/4/24 at 10:02 a.m. the Executive Director said the carpets were cleaned by a professional company three to four times per year for common areas. Staff also cleaned carpets in the common areas. When an apartment was vacated the carpet was cleaned. Tenant #2's apartment was cleaned almost monthly and in between was spot cleaned by staff. She said Tenant #2 urinated on the carpet at night and the carpet in his apartment had a urine odor. He had previously urinated on the floor quite a bit and it had improved with a toileting schedule change.	A 710		

Plan of Correction
Bickford Cottage Marion

A 125 481.67.2(1)d Program Policies and Procedures

Regulatory Insufficiency:
The program failed to have a policy and procedure regarding incident reports that had all required information.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Program Incident Report Policy has been updated to include statements from individuals who witness the incident.

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

- Vice President of Health & Wellness provided education to Health & Wellness Director on 8/29/24 on Incident Report Policy.
- Executive Director and Health and Wellness Director will re-educate staff on Incident Report Documentation policy and procedures on 9/4/24.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Health and Wellness or designee will review incident report documentation twice per year when completing on site visit and PRN.

Date deficiencies corrected by: 9/4/24

A 150 481-67.2(3) Program Policies and Procedures

Regulatory Insufficiency:
The program failed to follow policy and procedure related to completion of incident reports.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #2 no longer resides in the community.

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

- Vice President of Health & Wellness provided education to Health & Wellness Director on 8/29/24 on Incident Report Policy.
- Executive Director and Health and Wellness Director will re-educate staff on Incident Report Policy on 9/4/2024.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Health & Wellness or designee will review incident report documentation twice per year when completing on site visit and PRN.

Date deficiencies corrected by: 9/4/24

A 155 481-67.3(1) Tenant Rights

Regulatory Insufficiency:
The program failed to ensure 1 of 3 tenants reviewed was treated with consideration, respect, and full recognition or personal dignity, and autonomy.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #1 resides in Mary Bs apartment 137 and his door is always unlocked, except when he chooses to lock it himself while he is inside the apartment. His daughter may also lock the apartment during her visits for privacy.

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

- The Executive Director, Health & Wellness Director or designee will provide re-education to all staff members on 9/4/2024 on Resident Bill of Rights.
- The Executive Director will provide education on Resident Bill of Rights to all new staff members upon hire.

The program will monitor performance to ensure compliance as follows:

- The Director of Health & Wellness will interview residents during the assessment process regarding Resident Bill of Rights and report any concerns to the Executive Director for investigation and follow up.
- The Executive Director will investigate any staff concerns brought to attention with the assistance of the Health and Wellness Director.

Date deficiencies corrected by: 9/4/24

A 145 481-69.22(3) Evaluation of Tenant

Regulatory Insufficiency:
The program failed to complete evaluations as needed for significant change.

Plan of Correction

The insufficiencies will be corrected as follows:

- Tenant #2 no longer resides in the community.
- Tenant #1 health evaluation was completed on 08/29/2024

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

- Executive Director re-educated Health & Wellness Director on requirements of evaluation for changes in condition including but not limited to; changes in diet orders, care needs, pt orders, mobility, and cognitive status.
- Health & Wellness Director will re-educate all staff on 9/4/24 of the importance of communicating care changes for all residents to the Health and Wellness Director.

The program will monitor performance to ensure compliance as follows:

- Divisional Health & Wellness Director or designee will review resident charts twice per year during onsite visits or prn.

Date deficiencies corrected by: 09/04/24

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

Regulatory Insufficiency:
The program failed to discharge a tenant who exceeded retention criteria.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant #2 no longer resides in the community.

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

- Executive Director and Health & Wellness Director concerns with resident care level will be reported to Divisional Health & Wellness Director and Divisional Director of Operations.
- Residents who potentially exceed criteria for admission and retention will be discussed during weekly Higher Path care meetings.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Health & Wellness or designee will review tenant records to ensure compliance twice per year during onsite visits.

Date deficiencies corrected by: 9/4/24

A 350 481-69.26(1) Service Plans

Regulatory Insufficiency:
The program failed to update service plans as needed.

Plan of Correction:

The insufficiencies will be corrected as follows:

- **Tenant #1 –** Tenant #1 updated assessment completed to include health assessment on 8/29/2024
- **Tenant #2 –** Tenant #2 no longer resides in the community
- **Tenant #3 –** Tenant #3 no longer resides in the community

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

- Vice President of Health & Wellness provided education to the HWD on the Service Planning and Agreements policy on 8/29/24.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Health & Wellness or designee will audit service plans twice per year to ensure resident needs and preferences are noted on service plan.

Date deficiencies corrected by: 09/4/24

A 710 481-69.35(1) Structural Requirements

Regulatory Insufficiency:
The program failed to maintain a well-maintained, clean and safe building.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Bickford of Marion will receive a building remodel in the 2nd quarter of 2025. This remodel will include the flooring throughout the common area which will address the stains and frayed carpet.
- Common space carpets will continue to be professionally cleaned quarterly and prn by maintenance and staff.

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

- Executive Director will continue to have carpets in common spaces professionally cleaned quarterly and prn by maintenance.
- Executive Director and Maintenance Coordinator will ensure all individual apartment carpets will continue to be cleaned prn, upon move-out, and carpet will be replaced as needed to ensure they are well-maintained, clean, and in safe condition for all residents.
- All BFMs will be re-educated on 9/4/2 how/when to operate the shampoo machine for common space and apartment cleaning needs.

The program will monitor performance to ensure compliance as follows:

- Divisional Director of Health & Wellness or designee will audit service plans twice per year to ensure resident needs and preferences are noted on service plan.

Date deficiencies corrected by: 09/4/24