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 05/20/2026

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. Tenants without cognitive impairment: 22 Tenants with cognitive impairment: 15 Total census: 37 The following regulatory insufficiencies were cited during the investigation of Complaint #131255-C:	A 000	See attached POC 7/31/26	
A 102	481-67.2(1)a Program Policies and Procedures 67.2(1) A program's policies and procedures must meet the minimum standards set by applicable requirements. All programs shall have policies and procedures related to the following: a. Reporting of incidents, including allegations of dependent adult abuse on incident report forms to provide a detailed incident report completed at the time of the incident and include statements from individuals, if any, who witnessed the incident. The program will identify in the program's policy who of the program staff is responsible for completion of the initial report. The report will remain accessible for a minimum of three years. All accidents or unusual occurrences within the program's building or on the premises that affect tenants will be reported as incidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to develop and implement a policy and procedure for incident reports that included	A 102		

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

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A 102	Continued From page 1 specific record retention requirements. This systemic failure had the likelihood to affect all 37 tenants residing in the Program. Findings follow: Record review conducted on 5/19/26 and 5/20/26 of the Program's "Incident and Accident Report" policy and procedure revealed all incidents and accidents involving staff or tenants were to be reported to the Executive Director and the Health and Wellness Director. The policy directed that tenant incidents or accidents be documented in the electronic medical record, and that the person in charge at that time prepare and sign the report. Additionally, the policy mandated that the incident report include statements from individuals who witnessed the event. However, review of the incident report policy and procedure revealed it failed to include any requirements regarding the retention of these records. Continued record review of the Program's "Record Management" policy and procedure (related to record retention requirements) revealed the Program complied with all federal and state record management regulations. The policy directed that upon discharge, records could be stored at an off-site secured location, and that the Program retained records for 10 years after discharge before they were shredded. However, review of this policy verified it failed to address or include specific retention timelines for separate facility incident and accident reports. Further record review revealed the Program's "Incident and Accident Report" policy and procedure failed to identify incident reports must be maintained and accessible for a minimum of three years.	A 102		

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A 102	Continued From page 2 During an interview on 5/20/26 at 2:02 p.m., the Health and Wellness Director confirmed there was no record retention requirement included within the incident report policy and procedure. Subsequent to the interview, on 5/20/26 at 4:58 p.m., the Health and Wellness Director sent an email containing the "Record Management" policy, indicating the document specified how long incident reports were retained. However, review of the submitted record management policy verified it did not contain specific instructions ensuring incident and accident reports were retained and accessible for the required three-year period.	A 102		
A 115	481-67.2(1)n Program Policies and Procedures 67.2(1) A program's policies and procedures must meet the minimum standards set by applicable requirements. All programs shall have policies and procedures related to the following: n. Narcotics protocol, including policies and procedures related to reconciliation and destruction. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to develop and implement a comprehensive narcotic protocol including specific policies and procedures for narcotic medication reconciliation and destruction. This potentially affected all tenants receiving medications administered by the Program (35 tenants).	A 115		

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A 115	Continued From page 3 Findings follow: Record review on 5/19/26 and 5/20/26 o the Program's policy and procedure related to medication administration revealed staff were directed to follow policies and procedures for narcotics "in accordance with Iowa Code Chapter 155A." However, the policy failed to outline specific operational directives for staff regarding the handling, tracking, or disposal of these controlled substances. Continued record review of the Program's policy and procedure for medication storage revealed if a tenant was prescribed a controlled substance, the medications were to be secured in a locked cabinet or container within the locked apartment. Further record review verified the Program's policies and procedures failed to include any protocols, instructions, or requirements regarding the destruction or ongoing reconciliation of narcotic medications. During an interview on 5/20/26 at 2:02 p.m., the Health and Wellness Director confirmed that the Program had no specific written protocols or policies regarding narcotic reconciliation or destruction other than the general cross-reference to the Iowa Code.	A 115		
A 152	481-67.5(2)e(3) Medications 481-67.5(231B,231C,231D) Medications. 67.5(2)?Each program shall follow its own written medication policy, including the following: e. When medications are administered	A 152		

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A 152	Continued From page 4 traditionally by the program: (3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to administer medications as prescribed. This affected 1 of 1 tenant observed during a medication administration pass who was prescribed ophthalmic drops (Tenant #4), and 3 of 3 discharged tenants whose closed medical records were reviewed (Tenants C1, C2, and C3). Findings follow: 1. Observations conducted on 5/18/26 at approximately 4:12 p.m. and 4:30 p.m. revealed Staff A administered medications to four tenants, including Tenant #4. Review of Tenant #4's physician orders revealed an active directive for polyvinyl AL solution 1.4% ophthalmic drops: instill one drop in each eye, four times per day, including an administration at 4:00 p.m. During the observation, Staff A administered one drop of the polyvinyl AL solution 1.4% into Tenant #4's right eye only, failing to administer the medication in both eyes as ordered. Staff A also administered prednisolone 1% ophthalmic drops: instill one drop into the right eye, six times daily, with instructions to wait 3 to 5 minutes between different eye drops. Staff A administered one drop into the right eye but failed to wait the prescribed 3 to 5 minutes between the	A 152		

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different eye drop administrations. When asked about the eye drop ordered for both eyes (polyvinyl AL solution), Staff A stated that it was really just Tenant #4's right eye that bothered him, and she would document that it was only put in his right eye.

Record review on 5/20/26 of Tenant #4's May 2026 Medication Administration Record (MAR) revealed for the 5/18/26 4:00 p.m. administration, Staff A signed off verifying the administration of the polyvinyl AL solution 1.4% drop for both eyes. No charting was located within the medical record indicating the medication had been administered in the right eye only. Additionally, the MAR reflected Staff A signed off for the administration of the prednisolone 1% eye drop into the right eye at that time.

2. Record review on 5/19/26 of discharged Tenant C1's file revealed staff administered her medications and she received hospice services. A Patient Care Verbal Order dated 12/22/25 at 4:12 p.m. indicated the following directive:

Morphine Sulfate: administer 0.25 milliliters (ml) every six hours for pain or shortness of breath.

Continued record review revealed the December 2025 MAR reflected an order for morphine sulfate: give 0.25 by mouth every four hours for pain, with a start date of 12/22/25 and a stop date of 12/24/25. A total of nine doses were documented as administered between 12/22/25 and 12/24/25. The medication was ordered to be given every six hours but was administered by staff every four hours.

Further record review revealed the December 2025 MAR reflected an active order for

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lorazepam intensol 2 milligram (mg)/ml: give 0.25 ml (0.5 mg) by mouth three times per day as needed for restlessness. The record revealed this medication was administered on 12/2/25, and staff documented the reason given as "increased agitation/behavior." The medication was administered twice on 12/3/25; staff documented the reason for the first dose as "increased agitation and behavior," and the second dose as "increased agitation." Staff failed to administer this as-needed medication for its explicitly prescribed indication of restlessness, administering it instead for increased agitation and behavior.

3. Record review on 5/19/26 of discharged Tenant C2's file revealed a Patient Care Verbal Order dated 1/8/26 at 4:26 p.m. indicating the following orders:

Lorazepam 2 mg/ml: administer 0.25 ml, every four hours. Start date 1/8/26.

Lorazepam 2 mg/ml: administer 0.25 ml, every hour as needed for anxiety. Start date 1/8/26.

Morphine sulfate 20 mg/ml: administer 0.25 ml, every four hours as needed for pain or shortness of breath. Start date 1/8/26.

Morphine sulfate 20 mg/ml: administer 0.25 ml every hour as needed for pain or shortness of breath. Start date 1/8/26.

Discontinue lorazepam 2 mg/ml: administer 0.25 ml every four hours as needed for anxiety, agitation, restlessness. Discontinue effective 1/8/26.

Discontinue morphine 20 mg/ml oral concentrate:

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administer 0.25 ml, orally, every four hours as needed for pain, shortness of breath, air hunger. Discontinue effective 1/8/26.

Continued record review of the January 2026 MAR revealed the newly prescribed scheduled orders for lorazepam 2 mg/ml (give 0.25 ml by mouth every four hours) and morphine sulfate (give 0.25 ml by mouth every four hours) were listed on the active record; however, staff failed to document any administered doses of these scheduled medications.

Conversely, the January 2026 MAR revealed that the discontinued order for lorazepam concentrate 2 mg/ml (administer 0.25 ml every four hours as needed) was administered by staff on 1/8/26 at 1:36 p.m. (prior to the discontinuation of the order) and again at 8:09 p.m. after the discontinuation of the order. Additionally, the discontinued order for morphine sulfate (administer 0.25 ml every four hours as needed) was documented as administered by staff at 8:09 p.m., after the discontinuation of the order. The MAR verified the official discontinuation date and time for both historical orders was 1/8/26 at 4:00 p.m.

4. Record review on 5/19/26 and 5/20/26 of discharged Tenant C3's file revealed Tenant C3 was a type 1 diabetic and received hospice services. The July to September 2025 MARs reflected a practitioner's order to check her blood glucose eight times per day and call if her blood glucose was greater than 500. The July to September 2025 MARs documented multiple blood glucose readings over 500. Continued record review revealed Tenant C3's medical file lacked any documentation verifying that staff notified the primary care provider (PCP) as

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A 152	Continued From page 8 ordered for the blood glucose readings greater than 500. 5. During an interview on 5/20/26 at 2:02 p.m., the Health and Wellness Director stated it was possible hospice changed the morphine order interval to four hours (from six hours) for Tenant C1, though no documentation supporting this modification was located in the file. The Health and Wellness Director stated regarding Tenant C2 that three doses of as-needed Ativan were administered. The Health and Wellness Director confirmed the accuracy of the remaining noncompliance findings concerning Tenants #4, C1, C2, and C3.	A 152		
A 200	481-67.9(4)f Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4)?Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall include the following: f. Services will be provided to tenants in accordance with the training provided. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure care and services were provided in accordance with the tenant's individual service plan and established staff training guidelines. This pertained to 1 of 3 current tenants reviewed (Tenant #1). Findings follow:	A 200		

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A 200	Continued From page 9 Record review on 5/19/26 of Tenant #1's file revealed diagnoses that included dementia. The record indicated Tenant #1 was staged at a level four on the Global Deterioration Scale (GDS), indicating moderate cognitive decline. Review of Tenant #1's individual service plan revealed she required full assistance with all aspects of toileting and hygiene, with staff assistance scheduled upon waking up, before and after meals, at bedtime, and twice during the night. The service plan noted Tenant #1 resisted changing her soiled brief because she felt they were too expensive. Staff instructions directed them to remind her that not changing her brief could lead to a urinary tract infection (UTI) and subsequent expensive antibiotic costs. The service plan further indicated Tenant #1 frequently became upset during bathing and toileting. Explicit behavioral interventions directed staff to use a calm voice, attempt to redirect her, step back and re-approach, or change staff members if she continued to refuse care. During an interview on 5/19/26 at 1:51 p.m., Staff B stated that morning, Tenant #1 did not want to get changed. Staff B assisted Staff C with the care, noting it required a two-staff approach to remove her soiled protective undergarment because Tenant #1 kicked and punched. Staff B stated Tenant #1 was frequently combative during care and would hit, spit, and kick. Staff B stated if a tenant was combative, staff were supposed to step back and re-approach, but noted some staff were scared of Tenant #1. Staff B stated a two-person approach worked better because the	A 200		

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second person could watch Tenant #1's hands so she did not hit staff, while also providing a distraction. Staff B added Staff A would just "go in and get it done" when providing care to the tenant.

Record review of the Program's employee files on 5/19/26 revealed dementia training had been completed for four direct care staff members, including Staff B and Staff C.

Continued record review of Tenant #1's March through May 2026 Medication Administration Records (MARs) revealed a physician's order for lorazepam: ½ tablet (0.25 milligrams) orally once daily as needed prior to showers or personal care for severe agitation. Review of the MARs verified zero doses of this pre-care medication were administered during the months of March, April, or May 2026.

Continued record review of Tenant #1's "Notes and Incidents" (nurse's notes) spanning from 1/13/26 to 3/1/26 revealed multiple documented instances of combative behaviors directed toward staff during care routines, including yelling, swatting, grabbing staff inappropriately, scratching, hitting, pulling hair, and spitting. The documentation verified that multiple staff members were repeatedly utilized to physically manage care rather than utilizing the service plan's mandated step-back and re-approach techniques:

A nurse's note dated 1/28/26 indicated two staff members were utilized for toileting. Tenant #1 became combative during the process, scratching one staff member on the neck, pulling her hair, grabbing the second staff member by the shirt, and pushing her to the floor and the bed.

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A 200	Continued From page 11 A nurse's note dated 2/5/26 indicated Tenant #1 became highly agitated while staff members were completing her personal care, attempting to hit and kick the employees throughout the process. During an interview on 5/20/26 at 2:02 p.m., the Health and Wellness Director stated the proper protocol for Tenant #1 was to re-approach her, make care fun, and make it her idea. She stated for bathing, staff needed to catch her before she was fully dressed for the day. She noted while a shower might occasionally require two people, regular toileting should be handled by one person. The Health and Wellness Director confirmed Tenant #1 had an active as-needed medication order intended for use prior to the provision of care, and verified that if the tenant became combative and was safe, staff were trained to stop, let her calm down, and then re-approach. She confirmed these behavioral interventions were regularly discussed at monthly staff meetings and were included in the Program's required dementia training. The Health and Wellness Director confirmed staff failed to implement the individual service plan interventions, failed to utilize the prescribed as-needed behavioral medication, and failed to provide cares in accordance with the behavioral and re-approach methodologies established in their training.	A 200		
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	A 145		

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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 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 ensure comprehensive evaluations were completed as required to address a significant change in a tenant's physical, behavioral, or clinical condition. This noncompliance pertained to 2 of 3 current tenants reviewed (Tenant #1 and Tenant #2) and 3 of 3 discharged tenants reviewed (Tenants C1, C2, and C3).

Findings follow:

1. Record review on 5/20/26 of Tenant #1's file revealed "Notes and Incidents" (nurse's notes) spanning from 1/13/26 to 3/1/26 documented recurrent combative behaviors towards staff during care routines. Documented behaviors included yelling, swatting, grabbing staff in inappropriate areas, scratching, hitting, pulling hair, and spitting.

A nurse's note dated 1/28/26 indicated the provision of toileting care required a two-staff approach due to combativeness. The tenant

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scratched one staff member on the neck, pulled her hair, grabbed a second staff member by the shirt, and pushed her to the floor and the bed.

A nurse's note dated 2/5/26 indicated Tenant #1 became highly agitated during personal care, attempting to hit and kick staff members.

Continued record review revealed the Program completed evaluations for Tenant #1 on 3/6/26. The Program failed to complete timely evaluations when the acute behavioral changes occurred between January and February 2026.

2. Record review on 5/20/26 of Tenant #2's file revealed nurse's notes documenting an acute decline in physical mobility, requiring staff resources exceeding standard facility operations:

A nurse's note dated 5/2/26 indicated staff reported Tenant #2 required the assistance of three staff members to toilet the prior night. Tenant #2 failed to stand independently or assist with the transfer.

A nurse's note dated 5/2/26 indicated Tenant #2 required three-staff assistance for all day and evening transfers.

A nurse's note dated 5/3/26 indicated Tenant #2 required three-staff assistance for transfers and utilized a wheelchair for all ambulation.

A nurse's note dated 5/6/26 indicated Tenant #2 required three-staff assistance for toileting, was unable to stand for transfers, required personal care in bed, and screamed out in pain when touched.

A nurse's note dated 5/6/26 indicated Tenant #2

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A 145	Continued From page 14	A 145		

required three-person assistance in conjunction with hospice services.

A nurse's note dated 5/7/26 indicated Tenant #2 required three-staff assistance for toileting, utilizing one staff member on each side and one staff member in front to prevent a fall.

A nurse's note dated 5/11/26 indicated Tenant #2's family was notified the tenant exceeded the facility level of care, and the family agreed to seek placement in a long-term care facility.

Continued record review revealed the Program completed routine evaluations for Tenant #2 on 5/1/26. The Program failed to complete subsequent evaluations to address the significant change in condition involving the sudden need for three-staff assistance, the total inability to stand, and signs of severe pain during care.

3. Record review on 5/19/26 of discharged Tenant C1's file revealed nurse's notes documenting severe, progressive behavioral and physical changes throughout December 2025:

On 12/3/25, notes indicated Tenant C1 was combative during toileting and spit in a staff member's face. A late entry on the same date indicated the tenant hit staff with a closed fist; administered as-needed medication was ineffective.

On 12/4/25, notes indicated Tenant C1 displayed physical aggression towards other tenants in the dining room, attempted to bite a staff member's hand and arm during redirection, pulled table linens and glassware off dining tables, and frightened other tenants by hitting their chairs with her walker.

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A 145	Continued From page 15 On 12/6/25, notes indicated Tenant C1 ambulated at an "extremely slower pace." On 12/8/25, notes indicated Tenant C1 attempted to throw leftover food at staff, threatened staff with a closed fist during medication administration, and slapped her crushed medications away, throwing them onto herself and staff. On 12/15/25, notes indicated Tenant C1 attempted to walk without her walker, requiring transport via wheelchair. On 12/17/25, notes indicated Tenant C1 slept her entire shift, refused toileting, required care in bed, and attempted to pinch staff during toileting and cream application. On 12/19/25 and 12/20/25, notes indicated Tenant C1 utilized a wheelchair, experienced difficulty moving, and slept in her room her entire shift. On 12/22/25, notes indicated Tenant C1 required assistance to get out of bed and complained of pain during repositioning. Continued record review revealed the Program completed evaluations for Tenant C1 on 12/8/25. The Program failed to complete any evaluations when the initial severe physical aggression began on 12/3/25. Furthermore, the Program failed to complete subsequent evaluations as needed to address significant post-12/8/25 changes involving the loss of independent ambulation, increased somnolence, and pain during repositioning.	A 145		

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A 145	Continued From page 16 4. Record review on 5/19/26 of discharged Tenant C2's file revealed nurse's notes documenting progressive, unaddressed weight loss: A nurse's note dated 11/8/25 indicated Tenant C2 experienced a five-pound weight loss over the preceding month, with hospice notified. A nurse's note dated 12/9/25 indicated Tenant C2 lost an additional six pounds over the preceding month, with hospice and family notified. A nurse's note dated 1/5/26 indicated receipt of a physician's order for a protein shake twice daily. Continued record review verified Tenant C2 sustained a total cumulative weight loss of 18 pounds between 10/13/25 and 12/6/25. The Program failed to complete an evaluation addressing this significant change in nutritional status. 5. Record review on 5/19/26 and 5/20/26 of discharged Tenant C3's file revealed nurse's notes documenting a rapid clinical decline: A nurse's note dated 8/26/25 indicated an upcoming evaluation by hospice for program admission. A nurse's note dated 9/6/25 indicated completion of a change of condition form due to Tenant C3's official admission to hospice. Nurse's notes dated 9/14/25 indicated orders to reposition Tenant C3 every two hours, the delivery of a hospital bed, and a documentation note stating the tenant was no longer able to verbalize discomfort or pain.	A 145		

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A 145	Continued From page 17 A nurse's note dated 9/15/25 indicated Tenant C3 moaned in pain during repositioning, requiring the administration of as-needed morphine. On the same date, a new order discontinued all oral medications with the exception of comfort medications. A nurse's note dated 9/16/25 indicated Tenant C3 died. Review of the file revealed the Program completed the last evaluation on 9/6/25. The Program failed to complete any subsequent evaluations to address the severe, acute change in clinical status occurring after 9/14/25, including the loss of verbal communication, the development of severe pain during repositioning, the integration of a specialized hospital bed, and the discontinuation of routine medications. 6. During an interview on 5/20/26 at 2:02 p.m., the Health and Wellness Director confirmed the Program failed to complete evaluations as needed to address these significant changes in tenant condition.	A 145		
A 320	481-69.25(1)o Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record)	A 320		

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A 320	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure separate incident reports were completed and maintained when required for tenant injuries and physical aggression towards staff and other residents. This noncompliance pertained to 1 of 3 discharged tenants reviewed (Tenant C1). Findings follow: Record review on 5/19/26 of discharged Tenant C1's file revealed "Notes and Incidents" (nurse's notes) documenting injuries of unknown source and multiple severe physical altercations involving staff and other tenants: A nurse's note dated 10/6/25 indicated Tenant C1 had two bruises located on her left and right wrists. A nurse's note dated 10/14/25 indicated staff were unable to obtain vital signs because Tenant C1 was combative, verbally abusive, and physically abusive towards staff. The tenant refused her as-needed medication, displaying intimidating body language noted as "not safe for herself." A nurse's note dated 12/3/25 indicated Tenant C1 was combative with staff during toileting and spit in a staff member's face. A late entry on the same date indicated the tenant hit staff with a closed fist, rendering administered as-needed medication ineffective. A nurse's note dated 12/4/25 indicated Tenant C1 displayed physical aggression towards other tenants in the dining room. When staff attempted	A 320		

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A 320	Continued From page 19 redirection, Tenant C1 leaned over, attempted to bite an employee's hand and arm, and pulled table linens and glassware off the tables. The note indicated her actions frightened other tenants when she pulled the linens and hit their chairs with her walker. A nurse's note dated 12/8/25 indicated Tenant C1 attempted to throw leftover food at staff when reminded to use her walker. When staff subsequently attempted medication administration, Tenant C1 threatened employees with a closed fist, slapped her crushed medications away, threw some onto herself, and attempted to rub the medication onto staff. Nurse's notes dated 12/17/25 indicated Tenant C1 attempted to pinch staff during toileting assistance, and attempted to hit and pinch staff during the application of a prescribed topical cream. Continued record review of Tenant C1's medical file verified a complete lack of formal facility incident or accident reports generated for any of the documented dates and events. During an interview on 5/20/26 at 2:02 p.m., the Health and Wellness Director confirmed the Program failed to complete incident reports for the referenced bruising, physical aggression, and staff-directed assaults.	A 320		
A 360	481-69.26(3) Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not	A 360		

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A 360	Continued From page 20 less than annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to ensure separate incident reports were completed and maintained when required for tenant injuries and physical aggression towards staff and other residents. This noncompliance pertained to 1 of 3 discharged tenants reviewed (Tenant C1). Findings follow: Record review on 5/19/26 of discharged Tenant C1's file revealed "Notes and Incidents" (nurse's notes) documenting injuries of unknown source and multiple severe physical altercations involving staff and other tenants: A nurse's note dated 10/6/25 indicated Tenant C1 had two bruises located on her left and right wrists. A nurse's note dated 10/14/25 indicated staff were unable to obtain vital signs because Tenant C1 was combative, verbally abusive, and physically abusive towards staff. The tenant refused her as-needed medication, displaying intimidating body language noted as "not safe for herself." A nurse's note dated 12/3/25 indicated Tenant C1 was combative with staff during toileting and spit in a staff member's face. A late entry on the same date indicated the tenant hit staff with a closed	A 360		

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A 360	Continued From page 21 fist, rendering administered as-needed medication ineffective. A nurse's note dated 12/4/25 indicated Tenant C1 displayed physical aggression towards other tenants in the dining room. When staff attempted redirection, Tenant C1 leaned over, attempted to bite an employee's hand and arm, and pulled table linens and glassware off the tables. The note indicated her actions frightened other tenants when she pulled the linens and hit their chairs with her walker. A nurse's note dated 12/8/25 indicated Tenant C1 attempted to throw leftover food at staff when reminded to use her walker. When staff subsequently attempted medication administration, Tenant C1 threatened employees with a closed fist, slapped her crushed medications away, threw some onto herself, and attempted to rub the medication onto staff. Nurse's notes dated 12/17/25 indicated Tenant C1 attempted to pinch staff during toileting assistance, and attempted to hit and pinch staff during the application of a prescribed topical cream. Continued record review of Tenant C1's file verified a complete lack of incident or accident reports generated for any of the documented dates and events. During an interview on 5/20/26 at 2:02 p.m., the Health and Wellness Director reviewed the medical records and verified the accuracy of the findings, confirming the Program failed to complete incident reports for the referenced bruising, physical aggression, and staff-directed assaults.	A 360		

DEPARTMENT OF INSPECTIONS AND APPEALS

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Plan of Correction

Bickford of Marion

Survey Completion Date 5/20/26

Date SOD received 7/6/26

481.67.2(1)a Program Policies and Procedures

The Program failed to develop and implement a policy and procedure for incident reports that included specific record retention requirements.

This insufficiency was corrected by:

The ED verified that the branch's incident and accident reporting procedures meet regulation. The record retention guidelines were compiled and made accessible for review (attached).

To prevent the insufficiency from happening again:

The Divisional Director of Health and Wellness re-educated the ED and HWD on the branch's incident and accident reporting procedures and regulation on 7/13/26 during the divisional L10 meeting.

The ED, HWD or designee to review resident EHR to ensure incident and accident reports are present and complete for events requiring them per regulation on or before 7/30/26.

The ED is responsible for ensuring incident and accident reports are completed and retained in the EHR for a minimum of 3 years.

To monitor for ongoing compliance:

The Divisional Director of Health and Wellness will audit 20% of incident reports monthly for 6 months and annually thereafter to ensure compliance.

Date of Compliance JULY 30, 2026

481.67.2(1)n Program Policies and Procedures

The Program failed to develop and implement a policy and procedure for comprehensive narcotic protocol including specific policies and procedures for narcotic medication reconciliation and destruction.

This insufficiency was corrected by:

The HWD verified that the branch's medication management and pharmacy coordination procedures meet regulation. The medication management and pharmacy coordination procedures were compiled and made accessible for review (attached).

To prevent the insufficiency from happening again:

The Divisional Director of Health and Wellness re-educated the HWD on the medication management and pharmacy coordination procedures on 7/13/26 during the divisional L10 meeting.

The HWD or designee re-educated med passers on the narcotic reconciliation and destruction requirements on or before 7/30/26.

The HWD to review resident MAR's and narcotic count sheets to ensure proper reconciliation documentation is present on or before 7/30/26.

The HWD will conduct weekly medication audit to ensure narcotic reconciliation and destruction is completed and documented per regulation

The HWD is responsible for ensuring narcotic reconciliation and destruction are completed and documented in accordance with the narcotic protocol.

To monitor for ongoing compliance:

The Divisional Director of Health and Wellness will audit 20% of narcotic records monthly for 6 months and annually thereafter to ensure compliance.

Date of Compliance JULY 30, 2026

481.67.5(2)a(3) Medications

The Program failed to administer medications and treatments as prescribed by the resident's physician, ARNP or PA.

This insufficiency was corrected by:

HWD updated the clinical records for resident four to clarify eye drop administration instructions, and completed a clinical review of the medication administration records for discharged resident one, discharged resident two and discharged resident three.

Staff A removed from medication administration pending re-education and re- delegation.

To prevent the insufficiency from happening again:

DDHW re-educated HWD on medication administration and physician order adherence on 7/13/26.

HWD re-educated and re-delegated Med Techs on administering medications as prescribed, including eye drop spacing, following exact parameters, and verifying active/discontinued orders on or before 7/30/26.

HWD to audit all resident MARs to ensure active orders are transcribed correctly and discontinued orders are removed on or before 7/30/26.

HWD is responsible for ensuring medications are administered as prescribed by the physician, including following exact parameters, administration intervals, and notification protocols.

HWD to complete weekly medication audit to ensure continued compliance.

To monitor for ongoing compliance:

HWD will observe 5 medication passes per week for 12 weeks, and DDHW will audit 20% of medication observation logs and MARs monthly for 6 months and annually thereafter to ensure compliance.

Date of Compliance JULY 30, 2026

481.67.9(4)f Staffing

The Program failed to ensure care and services were provided in accordance with the resident's individual service plan and established staff training guidelines.

This insufficiency was corrected by:

HWD updated resident one's service plan to clarify behavioral interventions and pre-care medication administration protocols and completed competency re-validation on dementia care and re-approach techniques for Staff A, Staff B and Staff C on or before 7/30/26.

To prevent the insufficiency from happening again:

DDHW re-educated HWD on service plan adherence and dementia-specific behavioral interventions on 7/13/26.

HWD re-educated all care staff on step-back and re-approach techniques and utilizing prescribed pre-care medications on or before 7/30/26.

HWD completed a review of all resident EHRs to ensure behavioral interventions are accurately detailed in service plans on or before 7/30/26.

HWD will perform weekly shadowing of care staff on every shift to ensure appropriate implementation of resident plan of care, identify and provide additional training as indicated for the next three months and quarterly thereafter.

HWD is responsible for ensuring care is provided in accordance with resident service plans and established dementia training guidelines.

To monitor for ongoing compliance:

DDHW will audit 20% of observation logs with routine branch visits for 6 months and annually thereafter to ensure compliance.

Date of Compliance JULY 30, 2026

481.69.22(3) Evaluation of Tenant

The Program failed to ensure comprehensive evaluations were completed as required to address a signification change in a resident's physical, behavioral or clinical condition.

This insufficiency was corrected by:

HWD completed comprehensive evaluations for resident one and resident two to address their current clinical, behavioral, and physical status; discharged resident one, discharged resident two and discharged resident three are no longer residing at the branch.

To prevent the insufficiency from happening again:

DDHW re-educated HWD on completing tenant evaluations upon significant change in condition on 7/13/26.

HWD re-educated all branch staff on identifying and reporting significant changes on or before 7/30/26.

HWD to review all resident EHRs to ensure a comprehensive evaluation is completed for any resident experiencing a recent significant change on or before 7/30/26.

HWD is responsible for ensuring comprehensive evaluations are completed timely for any resident experiencing a significant change in physical, behavioral, or clinical status.

To monitor for ongoing compliance:

DDHW will audit 20% of resident records with routine visits for 6 months and annually thereafter to ensure compliance.

Date of Compliance JULY 30, 2026

481.69.25(1)o Tenant Documents

The Program failed to ensure separate incident reports were completed and maintained when required for resident injuries and physical aggression towards staff and other residents.

This insufficiency was corrected by:

HWD completed and filed retrospective incident reports in the electronic health record for the documented bruising and physical aggression events involving the affected resident.

To prevent the insufficiency from happening again:

DDHW re-educated the ED and HWD on incident and accident reporting procedures on 7/13/26.

ED and HWD re-educated all branch staff on reporting and documenting resident incidents immediately on or before 7/30/26.

ED and HWD reviewed all resident EHRs for the past thirty days to ensure all documented injuries and physical aggression events have corresponding incident reports on or before 7/30/26.

ED and HWD are responsible for ensuring incident reports are completed and maintained in the electronic health record immediately following any resident incident or accident.

To monitor for ongoing compliance:

DDHW will audit 20% of resident records with routine visits for 6 months and annually thereafter to ensure compliance.

Date of Compliance JULY 30, 2026

481.69.26(3) Service Plans

The Program failed to ensure separate incident reports were completed and maintained when required for resident injuries and physical aggression towards staff and other residents.

This insufficiency was corrected by:

Resident C1 no longer resides at Bickford.

To prevent the insufficiency from happening again:

DDHW re-educated the ED and HWD on the requirement to immediately document all resident injuries, wounds, and physical aggression incidents in the electronic health record on 7/13/26.

The ED and HWD then re-educated all branch staff on identifying and reporting these events on or before 7/30/26.

ED and HWD completed a review of all current resident progress notes from the past 30 days to identify any undocumented injuries or physical altercations and ensure corresponding incident reports were completed on or before 7/30/26.

ED and HWD are responsible for ensuring all resident injuries, wounds, and physical aggression incidents are documented in the electronic health record immediately following the occurrence and reviewed within 24 hours.

To monitor for ongoing compliance:

DDHW will audit 20% of resident progress notes and incident reports with routine visits for 6 months and annually thereafter to verify compliance.

Date of Compliance JULY 30, 2026