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
	S0043	A. BUILDING: _____ B. WING _____	C 04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE WEST DES MOINES	5050 HAWTHORNE DR WEST DES MOINES, IA 50265

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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: 31 Number of tenants with cognitive impairment: 2 Total census: 33 No regulatory insufficienies were cited during the investigations of Complaints #121111-C and #121112-C. The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000	The Plan of Correction is attached	
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 retained 1 of 4 tenants reviewed who routinely required two staff to assist with transfers (Tenant #3). Findings follow:	A 155		

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A 155	Continued From page 1 Record review on 3/1/25 revealed Tenant #3 admitted to the program on 9/13/23. An assessment for Tenant #3 dated 3/13/25 identified she required two-person assistance with transferring under the sections titled "Transfer" and "Enhanced Needs." The assessment further indicated Tenant #3 required two-person assist with toileting, full assistance with bathing and mobility support in the shower, full assistance with mobility requiring the use of a gait belt and wheelchair, full assistance with dressing, and moderate assistance with grooming and dental care. Tenant #3 was identified as a Level 3-High Fall risk. She was further identified on the assessment as having special care needs requiring frequent and ongoing max assistance due to, and including, a diagnosis of hemiplegia and hemiparesis following intracerebral hemorrhage affecting her left non-dominate side. The Health Assessment portion of the document indicated Tenant #3 had limited range of motion of the lower extremity (hips, leg, foot), but did not indicate contractures were a concern. The cognitive assessment revealed score of 3-4 on the Global Deterioration Scale (GDS) indicating mild to moderate cognitive decline. A service plan dated 3/13/25 revealed the category entitled "Transfer" which identified Tenant #3 required one-person assistance with resident participation, and included a bullet point which indicated Tenant #3 required two-person assistance with transferring. Notes in this section revealed Tenant #3 "utilizes a wheelchair for mobility. (Staff) will provide transfer assist x1 (2 intermittently). Tenant #3 is able to transfer using a 'bear' hug pivot transfer or by using a pivot disc. (Staff) will also utilize a Posey belt when transferring [Tenant #3]. After the transfer is	A 155		

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A 155	Continued From page 2	A 155		

completed, (staff) will take the Posey belt off. (Staff) will assist [Tenant #3] with all escorts to and from all meals and activities. At times [Tenant #3] can be tired and may require assistance x2 when transferring. It is very important that (staff) clearly communicate to [Tenant #3] what they are going to do and what they want her to do during the transfer."

An undated document identified as a "task sheet" further revealed Tenant #3 required "Maximum" daily assistance for toileting and "Moderate" assistance for transferring and included a two-person icon for both toileting and transfers.

An incident report dated 1/6/2025 revealed an incident when an unidentified caregiver reported she had assisted Tenant #3 in getting ready for the day, and as she was pulling up her pants, Tenant #3 fell forward and hit her head on her bed. The unidentified caregiver reported it to one of the Med Technicians on duty who completed the incident report. The incident report stated Tenant #3 had a red mark on her forehead and complained of a headache, but vitals and range of motion (ROM) were within Tenant #3's normal limits. A follow-up late entry note dated 1/7/25 completed by the Director of Health and Wellness (DHW) indicated a "rug burn noted to forehead" but no noted bruising or complaints of pain. Reminders were given to staff to use the posey belt with Tenant #3. A nurse's progress note dated 1/14/25 completed by the DHW indicated per an Emergency Department visit Tenant #3 did not have a fracture. The note further revealed the Physician Assistant-Certified (PA-C) had reviewed Tenant #3 and ordered physical and occupational therapy services (PT/OT) "for left hip pain and contractures from old CVA."

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A 155	Continued From page 3 During an interview on 3/31/25 at 11:12 am, Staff A stated she believed Tenant #3 should be at a higher level of care. Tenant #3 was pretty much a two-person assist all the time. She stated the program had requested staff to transfer Tenant #3 as an assist of one and using a "pulley type of thing" but staff utilized two people to assist Tenant #3. Staff A reported Tenant #3 couldn't stand on her own and did not bear weight as one leg was not able to correctly touch the ground at all. Staff A further reported Tenant #3 "will lock up on us and she really can't pivot." During an interview on 3/31/25 at 11:22 am, Staff B agreed Tenant #3 required the assistance of two staff for her needs. During observations and brief interview on 3/31/25 at 2:50 pm, Tenant #3 was seated in her wheelchair in her room and presented with a large wet spot in the groin area on her sweatpants. She stated she had "a mess here" and reported she had been paging staff. When questioned, the two staff on duty (Staff G and Staff H) stated no calls from Tenant #3 had been received but would provide assistence to the tenant. At 3:10 pm, Staff H entered Tenant #3's room, and then exited and approached Staff G to request help and returned to Tenant #3's room. At 3:12 pm Staff G entered Tenant #3's room and assisted Staff H with Tenant #3's care needs. Tenant #3 was observed approximately 15 minutes later to have been attended to with a clean/dry change of pants. During observations on 4/1/25 at 9:30 am, Staff C approached Staff D in the front lobby/dining room area to ask for assistance with transferring Tenant #3. Observation continued in Tenant #3's room. Staff C had assisted Tenant #3 with lower	A 155		

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A 155	Continued From page 4	A 155		

body cares and she laid on her side on the edge of her bed with her incontinence brief and pants half up, prepped for pants to be fully pulled up. Both staff verbally instructed Tenant #3 throughout the interaction, with little participation or success from Tenant #3. It required both Staff C and Staff D to attempt to first rotate Tenant #3 and then stand Tenant #3 as they pulled up her brief and pants. Both staff then sat Tenant #3 on the edge of her bed to rest and reposition in preparation for the transfer to her wheelchair. Tenant #3 required both staff to stand and attempt to pivot. Tenant #3's legs were slightly contracted and she bore very little weight or aid during the transfer. When questioned, Staff C and Staff D both confirmed Tenant #3 required two-person assistance for transfers and other tasks. The tenant appeared unable to do a "bear" hug technique and no gait belt/posey belt or pivot disc was used during the transfers.

During an interview on 4/1/25 at 10:43 am, Staff E stated Tenant #3 required an assistance of two staff and "that's always been the case since I started approximately one year ago." Staff E stated she was told during her initial training Tenant #3 required 2-person assistance. She further stated Tenant #3 "can't set her foot down completely, just her tippy toes, so she can't bear weight." There used to be a posey belt in the room, but then it would be gone for a while, then one would reappear for a while. Staff E stated staff used two-staff for transfers and staff are using the under-the-arm lifting technique, but Tenant #3 sometimes complained of pain when doing so. Staff E stated Tenant #3 "puts all her weight down on our arms" and "weight-bearing is all on our arms." Staff E stated that she and other caregiving staff have continually reported to nursing management about the concern for their

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A 155	Continued From page 5	A 155		

own safety due to some staff being older and the difficulty in transferring Tenant #3. She felt the staff's concerns were not being taken seriously and stated nursing management would instruct her to better instruct Tenant #3 on assisting with the transfer steps but then would eventually instruct staff to use two people. Staff E stated Tenant #3 "is the biggest concern for the two-person assist." She recalled during her training at the program her trainer introduced her to Tenant #3 and the trainer informed Staff E "we'll toilet her but it's going to take both of us. She's been a 2-person assist since I can remember." Staff E stated Tenant #3 "stiffens up her body and her left side she won't put down due to her stroke."

During observations on 4/1/25 at 11:40 am, Staff C approached Staff F in the front lobby/dining room to ask for assistance with Tenant #3 as she needed to use the restroom. Observation continued in Tenant #3's room. Both staff did well at verbally instructing Tenant #3 who stated she thought she could attempt to transfer to the toilet. Multiple verbal attempts by both aides were offered to instruct Tenant #3 to place her hands on the bathroom assist bar and stand, but the tenant was unable to use her right arm and bore very little weight, toes up against the edge of the bathroom wall, and leaning backwards on the caregiver's arms. Staff did attempt to stand Tenant #3 with the tenant attempting to hold onto the grab bar with one hand, but staff was clearly strained in an attempt to hold the tenant upright while simultaneously pulling down her pants. The two staff were able to hold Tenant #3 up for approximately one minute while continuing to attempt the transfer, but were unable to even pull down the tenant's pants due to the effort in holding her up. Staff C stated to Tenant #3 that

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A 155	Continued From page 6	A 155		

they would have to change and complete cares by laying her in her bed and she agreed and the tenant was lowered back to her wheelchair. Staff C commented how dangerous the attempt was for both themselves and the tenant and Staff F agreed. Staff C confirmed Tenant #3 requires two-person assistance and had been such the entire time she had cared for the tenant. Both staff then transferred the tenant to the bed to complete cares and then both staff transferred back to wheelchair. The tenant appeared unable to do a "bear" hug technique and no gait belt/posey belt or pivot disc was used during the transfers.

During an interview on 4/1/25 at 12:10 pm, the Physician Assistant-Certified (PA-C) who was present on site and had a history of providing care for Tenant #3 was questioned about Tenant's #3's assistance level needs. The PA-C stated she was aware of recent therapy services being attempted and believed therapy services due to pain in her left hip had been successful, but was unsure on what the discharge summary from therapy services had said.

During a follow-up interview with Tenant #3 on 4/1/25 at 2:30 pm, she stated two staff always helped transfer her and had done so for a long time. She was aware of no staff at the program that could transfer her by themselves.

During an interview on 4/1/25 at 3:11 pm the Director of Health and Wellness (DHW) was questioned on the concern with the use of two staff to complete the transfers of Tenant #3. The DHW stated staff had been trained on the one-person transfer technique with use of a posey belt for Tenant #3. She stated a posey belt had been placed in Tenant #3's room, but was

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A 155	Continued From page 7 gone for a while when Tenant #3's son borrowed it for an outing and failed to return it, prompting the DHW to order more posey belts. Once the order arrived another posey belt would be placed in the room. The DHW maintained Tenant #3 could be transferred with an assistance of one staff member, but she herself could not demonstrate due to recent shoulder surgery and surgery restrictions. She stated therapy services had been provided due to Tenant #3 complaining of left hip pain and she was just recently discharged from those services. On 4/1/25 at 4:00 pm the Director of Health and Wellness confirmed these findings.	A 155		

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

Regulatory Insufficiency: Program retained 1 of 4 residents reviewed who routinely required two staff to assist with transfers.

Plan of Correction:

The insufficiencies will be corrected as follows:

- Tenant # 3 was given a 30 notice of discharge from the program on May 7, 2025.

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

- Divisional Director of Health and Wellness provided re-education to the Health and Wellness Director regarding Criteria for Admission/Retention of Tenants on 4/28/25.

The program will monitor performance to ensure compliance as follows:

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

Date deficiencies corrected by: May 7, 2025

✓ 7/28/25