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
	S0063	A. BUILDING: _____ B. WING _____	C 12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE II SIOUX CITY	4022 INDIAN HILLS DR SIOUX CITY, IA 51108

(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: 0 Tenants with cognitive impairment: 30 Total census: 30 No regulatory insufficiencies were cited during the investigation of Incidents #130237-I, #130595-I, #130877-I and Complaint #130719-C. The following regulatory insufficiencies were cited during the investigation of Incident #130809-M.	A 000	see attached POC 4/5/26	
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 established policy regarding incident and accident reporting for 1 of 8 tenants reviewed (Tenant #1). Finding follows: Record review on 12/02/25 revealed an incident report involving Tenant #1 on 11/10/25. The incident report was created by the Director of Health and Wellness (DHW) on 11/14/25, four days after the incident of suspected abuse occurred. A review of the Program's policy, Incident and Accident Report, revised 12/2024, directed all	A 150		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 150	Continued From page 1 incidents and accidents for residents to be reported and documented immediately after they occurred. During an interview on 12/10/25, the Director of Health and Wellness indicated she wasn't sure if the incident was something she was to put into the tenant's chart where others could see the information. The DHW waited to hear back from her divisional nurse and was getting caught up on her charting. During the exit on 12/10/25, the Executive Director, Assistant Director, and DHW confirmed the above findings.	A 150		
A 325	481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to provide adequate staff to meet tenants' identified needs for 1 of 8 tenants reviewed (Tenant #1), with the potential to affect other tenants residing in the program. Finding follows: Record review on 12/02/25 revealed Tenant #1 admitted to the Program on 6/24/23. Tenant #1's service plan, dated 8/31/25, identified Tenant #1 with a Global Deterioration Score of five, indicating moderately severe cognitive decline. Additionally, the service plan identified Tenant #1	A 325		

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A 325	Continued From page 2	A 325		

required moderate assistance with mobility and required one person assistance with all transfers and ambulating using her walker. The service plan noted Tenant #1's behavior of having anxiety with her Activities of Daily Living (ADLs) and ambulating.

A review of incident reports for Tenant #1 included, but not limited to, two incident reports both dated 6/16/25 where staff unsuccessfully attempted to transfer/ambulate Tenant #1 which resulted in Tenant #1 falling or being lowered to the ground and requiring additional staff assistance to complete the lift/transfer from the floor.

An incident report created 11/14/25 indicated an incident occurred involving Tenant #1 on 11/10/25. A review of the Program's internal SafelyYou video monitoring system regarding the incident revealed Staff A assisted Tenant #1 and Staff A attempted to transfer Tenant #1 from the bed to escort/ambulate to the bathroom, which resulted in Tenant #1 sliding to the floor from the bed. Staff A made an additional attempt to lift/transfer Tenant #1 from the floor, but was unsuccessful and required the assistance of additional staff.

Review of the program's internal investigation regarding the incident revealed a written statement from Staff A dated 11/13/25 which stated Staff A requested the assistance of Staff B (med aide) in assisting with Tenant #1's lift/transfer from the floor, but Staff B indicated she couldn't due to being pregnant.

During an interview on 12/08/25, Staff A reported Tenant #1 felt like dead-weight and had been resistant to the transfer. Staff A indicated when

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A 325	Continued From page 3	A 325		

she went to attempt the transfer, Tenant #1's feet slid and resulted in the tenant sliding from the bed onto the floor. Staff A made an attempt to lift/transfer Tenant #1 from the floor then exited the room. Staff A asked Staff B (med aide) for assistance with Tenant #1's lift/transfer from the floor, but Staff B refused to help. Staff A waited for the overnight staff to arrive for assistance with the lift/transfer of Tenant #1 from the floor. Staff A reported on the evening of the incident, only one staff was usually allowed to leave the shift early at 9:00 p.m., but on the evening of the incident two staff left early at 9:00 p.m., which left Staff A and Staff B as the only staff remaining in the Program.

Review of the Program's entrance form indicated the staffing pattern for the evening PM shift was three staff. A review of timecards for the evening shift (3:00 p.m.-11:00 p.m.) of the incident on 11/10/25 revealed four staff began the shift, but two of the four staff (Staff C and Staff D) left early at 9:03 p.m.

During an interview on 12/02/25 at 3:00 p.m. with the Director of Health and Wellness (DHW), indicated Staff B was the medication aide on duty on the night of the incident. According to the DHW, the medication aides are expected to watch the SafelyYou videos then should go to the apartment and respond, but all staff get the fall alert on the work phone device. The DHW indicated at the time of the incident, Staff B had no lifting/weight restrictions.

During follow-up with the Executive Director (ED) on 12/10/25 via email at 11:52 a.m., the Executive Director indicated if she recalled correctly, the Program had an employee quit without notice or a sudden termination and Staff C was assisting to cover the shift on the day of

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A 325	Continued From page 4	A 325		

the incident, but would need to look into the day's events more. The ED further indicated medication aides were able to complete care on the Program floor as well, it is not just the responsibility of the non-med aides.

The Program provided no further explanation regarding why two staff left early on the day of the incident, leaving only two staff instead of three per their staffing pattern as listed on their provided entrance form.

Review of the service plans of additional current tenants in the tenant sample noted the potential need for intermittent two person assistance with transfers and/or for other Activities of Daily Living (ADLs), for two of five tenants in the tenant sample which resided in the Program on the day of the incident, included:

Record review of tenants files included two sample tenants required assistance with transfers from staff in addition to Tenant #1. The files revealed the following:

a. Tenant #2's service plan, dated 3/20/25, identified a maximum assist needed for toileting and one person assist with intermittent two person assist with all transfers using a gait belt or wheelchair.

b. Tenant #4's service plan, dated 10/18/25, identified the need for moderate assistance and required a one-person assist for all transfers with intermittent two-person assistance as needed for safety, with frequent unscheduled requests with transferring assistance.

Due to only two staff present, but one staff not assisting with Tenant #1's lifting/transfer needs,

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A 325	Continued From page 5 the Program failed to provide sufficient staffing to meet tenant needs. During exit on 12/10/25, the Executive Director, Assistant Director, and DHW confirmed the above findings.	A 325		

BICKFORD COTTAGE II SIOUX CITY
PLAN OF CORRECTION

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

Regulatory Insufficiency: The program failed to follow policy and procedure established by the program regarding Incident and Accident Reporting.

Plan of Correction:

The insufficiency will be corrected as follows:

- HWD or HWC to notify ED/AD of all allegations of abuse/neglect immediately upon discovery

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

- Documentation to be audited daily in the EHR system by ED or designee. Major Incidents to be discussed on weekly Higher Path meetings
- Divisional Director of Health & Wellness will provide reeducation to the Health and Wellness Director and HWC regarding incident and accident reporting and documentation procedures and mandatory abuse/neglect reporting procedures
- The HWD will re-educate all associates on mandatory abuse/neglect and incident reporting and documentation procedures

The program will monitor performance to ensure compliance as follows:

- Divisional Director HWD to review Incident reporting policy and procedure with HWD and HWC
- Divisional Director HWD will review mandatory abuse/neglect reporting procedures with HWD and HWC
- **Date of deficiencies corrected by**: 4/5/2026

A 325 481-67.9(1) Staffing

Regulatory Insufficiency: The program failed to provide sufficient staffing

Plan of Correction:

The insufficiency will be corrected as follows:

- All associates will remain in the facility throughout the entirety of their shift to ensure safe staffing ratios
- Any staffing adjustments must be made directly to the associate's director for approval prior to adjustment being made

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

- re-education of staff regarding Bickford's policies of shift work. Bickford clearly states no BFM can leave early without prior approval from the Director and those in violation are subject to disciplinary measures.

- Re-education of staff regarding immediately report staffing shortages, associates who are scheduled but fail to report to work, etc. to their Director for further guidance;
- communicate schedule adjustments during Daily Roots stand up mtgs
- HWD will review care levels and care groups in August Health weekly, the facility's EHR system, to ensure all care levels and care groups are assigned appropriately, and will adjust care groups when needed
- cross-train non care staff (when appropriate) to assist with non-clinical support during crunch times

The program will monitor performance to ensure compliance as follows:

- ED will review associate punches in/out daily x 2 weeks, then weekly ongoing to ensure all associates are remaining in the facility throughout the duration of their scheduled shifts
- ED/HWD will submit weekly call response times and staffing schedules to Divisional HWD weekly x 4 then bi-weekly x 4 then monthly ongoing to ensure compliance

- **Date of deficiencies corrected by**: 4/5/2026