DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165326	A. BUILDING ______ B. WING ______	C 11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMFIELD CARE CENTER	800 NORTH DAVIS STREET BLOOMFIELD, IA 52537

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 12/10/2019 The following deficiency relates to investigation of mandatory #86235 and complaints #85418 and 86207-A. See the Federal Code of Regulations (42-CFR) Part 483, Subpart B. Complaints #85770 and #86209 were not substantiated.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the proper assistance with transfers for 1 of 5 sampled (Resident #1) which resulted in significant bruising. The facility reported a census of 60. Findings include: According to the Minimum Data Set assessment dated 10/31/19, Resident #1 had diagnoses of dementia, stroke, diabetes mellitus and congestive heart failure. Resident #1 had short	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Newman
TITLE: Administrator
(X6) DATE: 12/18/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Jill Schulte PC

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F 689	Continued From page 1	F 689		

and long-term memory impairments and required total staff assistance with transfers, dressing, toilet use and personal hygiene.

The Care Plan updated on 8/7/19 revealed Resident #1 directed the staff to provide assistance of two staff with a total mechanical lift.

According to the Late Entry Progress Note dated 9/17/19 at 4:30 p.m., Staff B documented a Nurse Aide summoned her to Resident #1's room. The Nurse Aide reported she pivot transferred Resident #1 from her bed to her wheelchair. The Nurse Aide walked behind the wheelchair to position Resident #1 in the wheelchair. Resident #1 slid forward and twisted her knees. Staff B assessed Resident #1's knees and saw no redness or swelling. Staff B palpated Resident #1's knees and she complained of pain and grimaced. At 7:48 p.m., Staff administered a Tylenol suppository for pain.

During an interview on 11/20/19 at 1:00 p.m., Staff A (Nurse Aide) stated on 9/17/19 she assisted Resident #1 up for supper. Staff A stated Resident #1 required a total mechanical lift, but her partner was busy helping someone else. Staff A transferred Resident #1 by herself. Staff A stood in front of Resident #1 and wrapped her arms under Resident #1's arms. Resident #1 held onto Staff A's arms. Staff A stated she did not use a gait belt. Resident #1 stood and maybe took a step as she pivoted and sat down onto the edge of the wheelchair. Staff A stated she moved behind Resident #1 to pull her up in the chair and before she could, Resident #1 fell forward to her right and onto her knee, twisting it. Staff A lifted Resident #1 off the floor by lifting under her arms. Staff A stated she then reported

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F 689	Continued From page 2	F 689		

the incident to Staff B. Staff A stated she had returned to work following maternity leave from May to August 2019 and Resident #1 required a total mechanical lift when she returned.

During an interview on 11/19/19 at 1:19 p.m., Staff B (Registered Nurse) stated Staff A summoned her to Resident #1's room. Staff B observed Resident #1 sitting in her wheelchair. Staff A reported she attempted to transfer Resident #1 by herself from the bed into her wheelchair. Staff A stated as she pivoted Resident #1 and sat her down on the wheelchair, Resident #1 slid forward and twisted her knees. Staff A stated she was aware Resident #1 required a total mechanical lift and denied Resident #1 ever hit the floor. Staff B stated she assessed Resident #1 noting tenderness in her knees, but no obvious injury. Staff B told staff B, this is why you follow the care plan. Later that evening Resident #1 guarded her right knee. Staff B failed to document the incident in the progress notes and failed to share what had happened with the on-coming nurse.

During an interview on 11/19/19 at 3:40 p.m., Staff C (Registered Nurse) stated during report on the morning of 9/18/19 she was told Resident #1 was complaining of knee pain. Staff C had no knowledge of the improper transfer that resulted in Resident #1 twisting her knee the day before. Staff C stated it was very unusual for Resident #1 to complain of pain, so she contacted the Nurse Practitioner and received an order for an x-ray. Staff C stated a day or so later, she heard an improper transfer injured her knee.

According to Progress Notes dated 9/18/19 at 7:27 a.m., Staff C documented the Nurse Aide

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F 689	Continued From page 3	F 689		

reported Resident #1 grimaced and guarded her left knee during cares. Staff C observed Resident #1 guard and rub her knee. Knee swollen without redness or bruising. Staff C notified the Nurse Practitioner.

According to the Progress Notes dated 9/18/19 at 8:40 a.m., the Nurse Practitioner noted Resident #1 had left knee pain and swelling and ordered an x-ray. At 9:45 a.m., Resident #1's x-ray results negative for fracture.

The Radiology Report dated 9/18/19 of left knee indicate bone density lateral to femoral component of total knee prosthesis may be part of the patella or even an old bone fragment. An acute bone fragment seems unlikely with no joint effusion.

In an interview on 11/19/19 at 12:51 p.m. and 11/21/19 at 2:05 p.m., the Assistant Director of Nursing (ADON) stated changed Resident #1 from a pivot transfer with assistance of two staff to a total mechanical lift transfer with assist of two. The ADON stated Resident #1 had started to decline and one day while assisting Resident #1 in the shower it was evident, she could not bear weight to transfer safely. The ADON stated when implementing a change in transfer status she updates the Care Plan and passes the information along to the nurse for report. The ADON verified the accuracy of the statement she typed on 9/30/19. The ADON stated Staff C informed her on 9/18/19 Resident #1 guarded her legs and had pain. Staff C reported Resident #1 had a pivot transfer, but unaware what happened to cause her leg pain. Staff C then called the nurse practitioner and received orders for an x-ray and pain medication. The ADON stated at

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F 689	Continued From page 4	F 689		

this time she did not observe any bruising, but noted some slight swelling to the knees and lower extremities. The ADON stated Staff C stated she had only heard a rumor that staff transferred Resident #1 improperly. On 9/23/19, the staff informed the ADON that Resident #1's condition had changed over the weekend and now had significant bruising to her lower legs.

During an interview on 11/19/19 at 4:55 p.m., the Director of Nursing (DON) stated she returned to work on Friday, 9/20/19, and several staff reported Resident #1 had pain in her legs. The DON stated she assessed Resident #1 and found no bruising or discoloration at the time and no pain or discomfort. On Monday, 9/23/19 there was a significant change in condition and Resident #1 was visibly uncomfortable. That same day the DON and the Administrator visited with Resident #1's daughter who was upset. The DON stated she initiated an investigation and interviewed Staff B on 9/24/19. Staff B stated two aides transferring Resident #1 and she slipped out of her wheelchair, but did not hit the floor, so Staff B did not fill out an incident report. The DON stated sometime during that week she had also spoken to Staff A. Staff A stated "they" got her up and she slipped out of the wheelchair as she was attempting to pull her up from behind. The DON stated she did not initially know Resident #1 required a total mechanical lift. On Friday, 9/27/19, the Corporate Nurse visited and Staff A re-enact the transfer. Staff A failed to use the total mechanical lift as directed by the Care Plan. The facility terminated Staff A.

According to the Progress Note dated 9/18/19 at 4:30 p.m., Staff B documented Resident #1 had a light bruise under her left knee and darker

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F 689	Continued From page 5 bruising on lateral aspect of right leg and under knee. According the Progress Notes dated 9/20/19 at 6:53 a.m., the Nurse Practitioner visited Resident#1 for swelling and bruising in bilateral lower extremities, pain, and limited movement. No falls, but she may have been standing/pivot transferred instead of lift transferred just prior to onset of symptoms. X-ray of left knee done yesterday was negative. Has swelling, bruising, and complains of pain worse since yesterday. The Nurse Practitioner noted Resident #1 had two plus pitting edema (swelling), right ankle with ecchymosis (bruising), left calf with ecchymosis, swelling to the left knee with possible effusion. Resident #1 winced with palpation of knees, thighs and hips. The Nurse Practitioner ordered additional x-rays of left femur, hip and pelvis and right knee, femur, hip and pelvis. Review of the Radiology Report dated 9/20/19 of bilateral pelvis, right and left femur and right knee on 9/20/19 revealed no acute fractures or abnormalities. According to the Progress Notes dated 9/22/19 at 10:47 a.m., Staff D (Registered Nurse) documented Resident #1's Primary Care Physician notified and orders obtained for additional pain medications for Resident #1's leg pain. At 2:07 p.m., Staff D summoned to Resident #1's room. Resident #1 had bruising both legs all the way to her feet with swelling of the posterior leg. According to the Progress Notes dated 9/23/19 at 1:39 p.m., the Nurse Practitioner documented Resident #1 had continued knee pain, bruising to	F 689		

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F 689	Continued From page 6 bilateral legs and posterior knees, right foot swelling and bruised arch. The Nurse Practitioner ordered an x-ray of the right foot. Radiology report dated 9/24/19 of right foot indicate no obvious fractures or dislocations. No acute right foot pathology. According to progress notes dated 9/25/19 at 8:00 a.m. by the DON, the DON notes Resident #1 with order for a CT scan that afternoon. According to progress notes dated 9/25/19 at 4:25 p.m. by Staff B, Staff B notes Resident #1 returned to facility following a CT scan and notes a family member claims resident has muscle strain-twisting and feels the facility has lied to her about the origins of her mother's injury. Radiology report dated 9/25/19 notes reason for exam osteopenia with history of fall and suspected fracture, CT scan of pelvis and left femur. Impression: negative CT study of the pelvis and left femur for evidence of occult fracture. According to the Progress Notes dated 9/26/19 at 6:00 p.m. by Staff B, Staff B notes Resident #1 with some facial grimacing with movement, but not as much as previously noted. Right foot remains edematous and bruising on right leg is dark purple with some yellow coloration noted. According to the Progress Notes dated 9/27/19 at 3:28 p.m. by the ADON, the ADON notes bruising to bilateral extremities still present upon assessment, there are no new areas of concern, bruising is in various stages of color and healing.	F 689		

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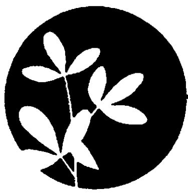
F 689	Continued From page 7 During an interview on 11/20/19 at 2:29 p.m., the Primary Care Physician indicated he was not aware of the total extent of Resident #1's injury in September. He understood the injury was the result of an improper transfer. The Physician reported Resident #1 had a quick decline in November and believed her cause of death was due to a myocardial infarction. The Physician stated given the time between the injury and her death, he did not believe the injury had any bearing on her decline or death.	F 689		



Bloomfield Care Center

800 N. Davis • Bloomfield, IA 5253

Ph: (641) 664-2699 • Fax: (641) 664-292

Date submitted: December 18th, 2019

Plan of correction related to survey completed November 26, 2019.

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under federal or state law.

F000 Correction Date: December 10, 2019

F 689 Free of Accident Hazards/Supervision/Duties
The facility ensures that the resident environment remains as free of accident hazards as is possible: and that each resident receives adequate supervision and assistance devices to prevent accidents.

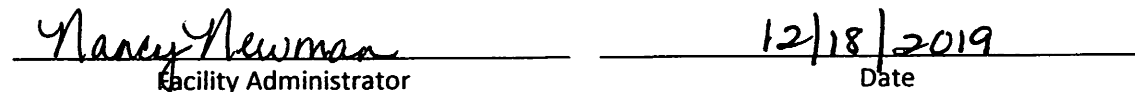
For the required plan of correction the facility submits the following:

1. Nursing staff received 1:1 re-education by the Director of Nursing on 9/27/19 instructing nurses to document "falls" and "near falls" on "incident report" forms/notes instead of "health status notes" in the electronic record. On 9/17/2019 p.m. following the occurrence the evening Charge Nurse documented the incident in a "health status note" along with a range of motion and pain examination on the resident in Resident #1's electronic record which also automatically appeared on the "24 hour shift report." On 9/18/2019 a.m. the day Charge Nurse notified the daughter and physician of the previous evening occurrence per facility policy.
2. The Evening and Day Charge nurses were provided one on one re-education by the Director of Nursing on facility standards for completing incident report forms in the electronic health record. Direct caregiver staff was provided re-education by the Director of Nursing and Rehabilitation Department of Proper Transfer Techniques on 10/08/2019, 10/23/2019, 10/28/2019. Following the October re-education in-service's Certified Nurse Aide Mechanical Lift Competencies were performed and supervised by the Director of Nursing, the Assistant Director of Nursing and Charge Nurses through November. On December 10, 2019 a follow up Proper Transfer Technique in-service was held for direct caregiver staff by the Director of Nursing and the Rehabilitation Department.
3. The Director of Nursing or designee will perform audits of Incident Reporting and proper transfer techniques monthly for 3 months. The results of the audits will be reviewed as part of our on-going quality assurance process and the frequency of audits monthly thereafter will be based on outcomes and subsequent recommendations.

Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 7069		Date: December 10, 2019
Facility Name: Bloomfield Care Center		Survey Dates: November 18 - 26, 2019
Facility Address/City/State/Zip 800 North Davis St Bloomfield, IA 52537	MW JS	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
58.28(3)e	**481—58.28(135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) (III) **58.28(3)** *Resident safety* *e.* Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) **DESCRIPTION:** Based on record review and staff interviews, the facility failed to provide the proper assistance with transfers for 1 of 5 sampled (Resident #1) which resulted in significant bruising. The facility reported a census of 60. Findings include: According to the Minimum Data Set assessment dated 10/31/19, Resident #1 had diagnoses of dementia, stroke, diabetes mellitus and congestive heart failure. Resident #1 had short and long-term memory impairments and required total staff assistance with transfers, dressing, toilet use and personal hygiene.	I	$6, 500	**Upon Receipt**



Facility Administrator Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

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	onto Staff A's arms. Staff A stated she did not use a gait belt. Resident #1 stood and maybe took a step as she pivoted and sat down onto the edge of the wheelchair. Staff A stated she moved behind Resident #1 to pull her up in the chair and before she could, Resident #1 fell forward to her right and onto her knee, twisting it. Staff A lifted Resident #1 off the floor by lifting under her arms. Staff A stated she then reported the incident to Staff B. Staff A stated she had returned to work following maternity leave from May to August 2019 and Resident #1 required a total mechanical lift when she returned. During an interview on 11/19/19 at 1:19 p.m., Staff B (Registered Nurse) stated Staff A summoned her to Resident #1's room. Staff B observed Resident #1 sitting in her wheelchair. Staff A reported she attempted to transfer Resident #1 by herself from the bed into her wheelchair. Staff A stated as she pivoted Resident #1 and sat her down on the wheelchair, Resident #1 slid forward and twisted her knees. Staff A stated she was aware Resident #1 required a total mechanical lift and denied Resident #1 ever hit the floor. Staff B stated she assessed Resident #1 noting tenderness in her knees, but no obvious			

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	injury. Staff B told staff B, this is why you follow the care plan. Later that evening Resident #1 guarded her right knee. Staff B failed to document the incident in the progress notes and failed to share what had happened with the on-coming nurse. During an interview on 11/19/19 at 3:40 p.m., Staff C (Registered Nurse) stated during report on the morning of 9/18/19 she was told Resident #1 was complaining of knee pain. Staff C had no knowledge of the improper transfer that resulted in Resident #1 twisting her knee the day before. Staff C stated it was very unusual for Resident #1 to complain of pain, so she contacted the Nurse Practitioner and received an order for an x-ray. Staff C stated a day or so later, she heard an improper transfer injured her knee. According to Progress Notes dated 9/18/19 at 7:27 a.m., Staff C documented the Nurse Aide reported Resident #1 grimaced and guarded her left knee during cares. Staff C observed Resident #1 guard and rub her knee. Knee swollen without redness or bruising. Staff C notified the Nurse Practitioner.			

Facility Administrator ____________ Date ____________

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	According to the Progress Notes dated 9/18/19 at 8:40 a.m., the Nurse Practitioner noted Resident #1 had left knee pain and swelling and ordered an x-ray. At 9:45 a.m., Resident #1's x-ray results negative for fracture. The Radiology Report dated 9/18/19 of left knee indicate bone density lateral to femoral component of total knee prosthesis may be part of the patella or even an old bone fragment. An acute bone fragment seems unlikely with no joint effusion. In an interview on 11/19/19 at 12:51 p.m. and 11/21/19 at 2:05 p.m., the Assistant Director of Nursing (ADON) stated changed Resident #1 from a pivot transfer with assistance of two staff to a total mechanical lift transfer with assist of two. The ADON stated Resident #1 had started to decline and one day while assisting Resident #1 in the shower it was evident, she could not bear weight to transfer safely. The ADON stated when implementing a change in transfer status she updates the Care Plan and passes the information along to the nurse for report. The ADON verified the accuracy of the statement she typed on 9/30/19. The ADON stated Staff C informed her			

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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	on 9/18/19 Resident #1 guarded her legs and had pain. Staff C reported Resident #1 had a pivot transfer, but unaware what happened to cause her leg pain. Staff C then called the nurse practitioner and received orders for an x-ray and pain medication. The ADON stated at this time she did not observe any bruising, but noted some slight swelling to the knees and lower extremities. The ADON stated Staff C stated she had only heard a rumor that staff transferred Resident #1 improperly. On 9/23/19, the staff informed the ADON that Resident #1's condition had changed over the weekend and now had significant bruising to her lower legs. During an interview on 11/19/19 at 4:55 p.m., the Director of Nursing (DON) stated she returned to work on Friday, 9/20/19, and several staff reported Resident #1 had pain in her legs. The DON stated she assessed Resident #1 and found no bruising or discoloration at the time and no pain or discomfort. On Monday, 9/23/19 there was a significant change in condition and Resident #1 was visibly uncomfortable. That same day the DON and the Administrator visited with Resident #1's daughter who was upset. The DON stated she initiated an investigation and interviewed			

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	Staff B on 9/24/19. Staff B stated two aides transferring Resident #1 and she slipped out of her wheelchair, but did not hit the floor, so Staff B did not fill out an incident report. The DON stated sometime during that week she had also spoken to Staff A. Staff A stated "they" got her up and she slipped out of the wheelchair as she was attempting to pull her up from behind. The DON stated she did not initially know Resident #1 required a total mechanical lift. On Friday, 9/27/19, the Corporate Nurse visited and Staff A re-enact the transfer. Staff A failed to use the total mechanical lift as directed by the Care Plan. The facility terminated Staff A. According to the Progress Note dated 9/18/19 at 4:30 p.m., Staff B documented Resident #1 had a light bruise under her left knee and darker bruising on lateral aspect of right leg and under knee. According the Progress Notes dated 9/20/19 at 6:53 a.m., the Nurse Practitioner visited Resident#1 for swelling and bruising in bilateral lower extremities, pain, and limited movement. No falls, but she may have been standing/pivot transferred instead of lift transferred just prior to			

Facility Administrator

Date

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Citation Number: 7069		Date: December 10, 2019
Facility Name: Bloomfield Care Center		Survey Dates: November 18 - 26, 2019
Facility Address/City/State/Zip 800 North Davis St Bloomfield, IA 52537	MW JS	

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	onset of symptoms. X-ray of left knee done yesterday was negative. Has swelling, bruising, and complains of pain worse since yesterday. The Nurse Practitioner noted Resident #1 had two plus pitting edema (swelling), right ankle with ecchymosis (bruising), left calf with ecchymosis, swelling to the left knee with possible effusion. Resident #1 winced with palpation of knees, thighs and hips. The Nurse Practitioner ordered additional x-rays of left femur, hip and pelvis and right knee, femur, hip and pelvis. Review of the Radiology Report dated 9/20/19 of bilateral pelvis, right and left femur and right knee on 9/20/19 revealed no acute fractures or abnormalities. According to the Progress Notes dated 9/22/19 at 10:47 a.m., Staff D (Registered Nurse) documented Resident #1's Primary Care Physician notified and orders obtained for additional pain medications for Resident #1's leg pain. At 2:07 p.m., Staff D summoned to Resident #1's room. Resident #1 had bruising both legs all the way to her feet with swelling of the posterior leg. According to the Progress Notes dated 9/23/19 at			

Facility Administrator Date

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Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 7069		Date: December 10, 2019
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Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
	1:39 p.m., the Nurse Practitioner documented Resident #1 had continued knee pain, bruising to bilateral legs and posterior knees, right foot swelling and bruised arch. The Nurse Practitioner ordered an x-ray of the right foot. Radiology report dated 9/24/19 of right foot indicate no obvious fractures or dislocations. No acute right foot pathology. According to progress notes dated 9/25/19 at 8:00 a.m. by the DON, the DON notes Resident #1 with order for a CT scan that afternoon. According to progress notes dated 9/25/19 at 4:25 p.m. by Staff B, Staff B notes Resident #1 returned to facility following a CT scan and notes a family member claims resident has muscle strain-twisting and feels the facility has lied to her about the origins of her mother's injury. Radiology report dated 9/25/19 notes reason for exam osteopenia with history of fall and suspected fracture, CT scan of pelvis and left femur. Impression: negative CT study of the pelvis and left femur for evidence of occult fracture.			

Facility Administrator Date

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	According to the Progress Notes dated 9/26/19 at 6:00 p.m. by Staff B, Staff B notes Resident #1 with some facial grimacing with movement, but not as much as previously noted. Right foot remains edematous and bruising on right leg is dark purple with some yellow coloration noted. According to the Progress Notes dated 9/27/19 at 3:28 p.m. by the ADON, the ADON notes bruising to bilateral extremities still present upon assessment, there are no new areas of concern, bruising is in various stages of color and healing. During an interview on 11/20/19 at 2:29 p.m., the Primary Care Physician indicated he was not aware of the total extent of Resident #1's injury in September. He understood the injury was the result of an improper transfer. The Physician reported Resident #1 had a quick decline in November and believed her cause of death was due to a myocardial infarction. The Physician stated given the time between the injury and her death, he did not believe the injury had any bearing on her decline or death. **FACILITY RESPONSE:**			

Facility Administrator   Date

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