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
	S0008	A. BUILDING _____ B. WING _____	C 08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE FORT DODGE	1536 20TH AVENUE N FORT DODGE, IA 50501

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A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 24 Number of tenants with cognitive disorder: 4 Total Population of Program at time of on-site: 28 TOTAL census of Assisted Living Program: 28 The following regulatory insufficiency was cited during the investigation of Incidents #64734-I, #67005-I and Complaint #67075-C.	A 000	See attached POC 9/18/17	
A 094	481-69.27(1)a Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: 69.27(1)a To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders.	A 094		

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

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A 094	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the Program failed to complete timely nurse review of a tenant after significant change. This affected 1 of 2 sample tenants (Tenant #2). Finding follows: According to an Incident Report dated 3-9-17 at 3:20 p.m., upon entering the tenant's room, staff found Tenant #2 on the floor. Range of motion was performed. Tenant #2 had no complaints of pain or apparent injury at that time. Tenant #2 denied hitting head. Vitals were taken, the nurse, physician and family were notified. According to an Incident Report dated 3-10-17 at 12:25 a.m., when doing rounds, staff found Tenant #2 on the floor between bed and night stand with his/her left leg caught under the bed causing bruising. A skin tear to left elbow measured 10 cm by 5.5 cm. Telfa was applied and the elbow was wrapped with gauze. Range of motion and neuro checks were okay. More bruising was noted to his/her left leg. The physician was notified by fax at 2:30 a.m. and the family was notified at 9:00 a.m. According to Progress Notes dated 3-10-17 at 9:30 a.m., the Registered Nurse Coordinator (RNC) documented Tenant #2 had two falls in less than 24 hours. The RNC called and notified family and also talked with Tenant #2's home health agency about the falls. After talking with family and home health agency it was decided to take Tenant #2's bed off the frame and put the mattress and box springs on the floor and the night stand was moved in front of one of the closet doors so it was further from the bed. The	A 094		

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A 094	Continued From page 2 notes did not include documentation of an assessment or nurse review. Additional review of progress notes revealed nurse review of Tenant #2 not completed until 12:30 p.m. on 3/10/17. According to a Nurse Review post fall, the RNC documented Tenant #2 was very tired at this time. Pupils were equal and reactive to light and Tenant #2 was able to move all four extremities at the time. Tenant #2 seemed to be guarding left arm slightly. Skin tears and bruising to the arm were present. Upon palpation to the arm, Tenant #2 denied pain. Tenant #2 followed commands when asked. An abrasion to the left temple measured 1.0 cm x 0.5 cm. and bruise to the left side of eye was red/brown in color and measured 4.0 cm x 2.0 cm. According to the Progress Notes dated 3-10-17 at 12:45 p.m., the RNC talked with Tenant #2's family and reported Tenant #2 was not acting like self. Family indicated they would like the Nurse Practitioner (NP) notified. A call was made to NP's office and the situation was explained to the NP's nurse, including the vitals. NP's nurse said she would have NP call back. Staff continued to monitor Tenant #2. At 3:31 p.m., a call was received from the NP's office and indicated the NP suggested Tenant #2 be sent to the ER or Urgent Care to be evaluated. The RNC spoke with Tenant #2's family who was agreeable to having Tenant #2 sent to the ER for evaluation. At 4:00 p.m. the non-emergent ambulance was called to transfer Tenant #2 to the ER as Tenant #2 was too weak to get into a car. At 6:34 p.m. a call was received from the ER stating Tenant #2 would be admitted to the hospital due to a significant brain bleed. On 3-13-17 a note in the Progress Notes indicated on 3-11-17, Tenant #2's	A 094		

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A 094	Continued From page 3 family notified the Program Tenant #2 was transferred to a hospice house. Review of Tenant #2's medical records revealed the following: a. A physician note documented,"(Patient) to (ER) per (ambulance) for altered mental status. (Patient)... has had altered mental status for (two) days. Stated (he/she) has fallen twice this morning, unsure of (Level of Care). States (he/she) has increased fatigue and lethargy for (two) days... Bickford states patient is normally alert to person and up with assist of a walker. Over the past (two) days, patient has been up with assist of (two) plus (staff). Patient has multiple skin tears and bruising scatted on arms legs and trunk. Patient lays in bed with (his/her) eyes half opened, unable to relate any pain but speech is slurred. b. The tenant received a CT scan upon arrival to the ER. The report documented: "Impression: Large subdural hematoma along the entire peripheral convexity of the right cerebrum..." On 4-27-17 at 9:30 a.m., the RNC was interviewed and stated staff reported Tenant #2 wasn't acting right. Tenant #2's family didn't like having Tenant #2 out of the building due to past war experiences. Going to the ER made Tenant #2 claustrophobic. Tenant #2 would have flashbacks. Tenant #2 was more tired than usual, seemed to have weakness on left side and was being treated for a UTI with an antibiotic. The Nurse was not sure what was going on with Tenant #2 so called the Nurse Practitioner (NP) who advised to send Tenant #2 to the ER. She called the family who agreed to the transfer. She stated the Program was trying new fall	A 094		

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A 094	Continued From page 4	A 094		

interventions constantly. Before Tenant #2 went to the ER, they had lowered the bed to the floor.

On 4-27-17 at 9:48 a.m., the Director was interviewed and stated the day Tenant #2 went to the hospital she was in Tenant #2's apartment and Tenant #2 was visiting with the RNC. Tenant #2 didn't look normal. The RNC contacted the NP and it was decided to send Tenant #2 to the ER.

On 4-27-17 at 10:10 a.m., the Divisional Nurse was interviewed and stated she was in the Program the day Tenant #2 went to the ER. A few days before, Tenant #2 was up walking with walker. Tenant #2 was being treated for a UTI. She really thought the UTI was the reason Tenant #2 didn't seem like self. She was shocked to hear Tenant #2 had a brain bleed.

On 8-17-17 at 8:54 a.m., the RNC was interviewed and stated when she contacted the NP's nurse she reported what she observed: Tenant #2 was not acting right, gait was off. Neurological checks were fine but Tenant #2 favored his/her left arm. Going to the ER always confused and made Tenant #2 anxious, thus family only wanted the RNC to call the NP's office and wait for direction before sending Tenant #2 out. She stated no additional contacts were made with the NP's office after she called at 12:45 p.m. and received a return call at 3:31 p.m. She stated she kept checking on Tenant #2 at least every hour and she stayed in contact with Tenant #2's family. She completed visual checks and spoke with Tenant #2. She did not see any change in Tenant #2 from the time she called the NP and the time the ambulance arrived. Tenant #2 was conscious and responding when the ambulance attendants picked up Tenant #2.

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A 094	Continued From page 5 In summary, the Program failed to ensure timely nurse review after a significant change in condition of a tenant. Tenant #2 experience two falls within a short amount of time: 3-9-17 at 3:20 p.m. and 3-10-17 at 12:25 a.m. Record review revealed no assessment or nurse review completed until 3-10-17 at 12:30 p.m.; more than 12 hours after the tenant fell and sustained injuries. Upon assessment, further medical attention was sought. Ultimately, the tenant was diagnosed with a large subdural hematoma.	A 094		

9/18/17 OK 9/18/17

Plan of Correction
Fort Dodge Bickford

A 094 Nurse Review

Regulatory Insufficiency: The program failed to complete timely nurse review of a tenant after significant change.

Plan of Correction:

The insufficiency will be corrected as follows:

- The RNC will ensure timely nurse reviews are completed with any significant changes in the resident's functional, cognitive and health status.

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

- The RNC was re-educated on the need to re-evaluate residents any time there is a significant change in the functional, cognitive or health status, on 09/08/2017.

The program will monitor performance to ensure compliance as follows:

- The Divisional Director of Resident Services will perform an annual audit of charts to ensure resident assessments of functional, cognitive and health status are completed with any significant changes.

Date deficiencies corrected: 09/08/2017

September 14, 2017

Catie Campbell, Program Coordinator
Adult Services Bureau
Lucas State Office Building
321 E 12th Street
Des Moines, Iowa 50319-0083

Dear Ms. Campbell:

This letter is in response to the Investigation of Complaint #67075-C visit from 4/26/17 to 04/27/17 at Fort Dodge Bickford.

The following document will serve as the written Plan of Correction addressing the regulatory insufficiency identified during the visit.

If you have additional questions and/or concerns, please contact me at 515-573-3300. Thank you for your time and consideration in this matter.

Sincerely,

Sarah Ratcliff

Sarah Ratcliff, Director
Fort Dodge Bickford