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
	S0024	A. BUILDING: _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE AMES	2418 KENT AVE AMES, IA 50010

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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 disorder: 32 Number of tenants with cognitive disorder: 5 TOTAL Census of Assisted Living Program for People with Dementia: 37 This Program has met criteria to be an Assisted Living Program for People with Dementia by definition for the last two recertification visits. During the investigation of Complaint #107558-C the following regulatory insufficiency was cited. There were no regulatory insufficiencies cited during the investigation of Complaint #108440-C.	A 000		
A 125	481-67.2(1)d Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: d. The incident report shall include statements from individuals, if any, who witnessed the incident. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the Program failed to ensure the completion of	A 125		

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A 125	Continued From page 1 incident reports included witness statements. This affected 1 of 3 tenants reviewed (Tenant #3). Finding follows: Record review on 11/10/22 revealed an incident report dated 8/30/22 at 7:45 a.m. The report documented Staff B was walking with Tenant #2 to the dining room when Tenant #2 fell backwards. Staff B said the tenant did not hit her head. After the fall the tenant was unresponsive. When turned on her side the tenant began seizing. The report did not include a statement from Staff B. On 2/12/23 the Program Director reported a witness statement from Staff B could not be located for the incident occurring 8/30/22. The Program Director had Staff B complete a witness statement 2/10/22.	A 125		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide tenants with adequate care, treatment and services. This pertained to 1 of 3 files reviewed (Tenant #2). Findings include: Record review on 11/10/22 revealed an incident	A 160		

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report, dated 8/30/22 at 7:45 a.m., documented documented Staff B walked with Tenant #2 towards the dining room when Tenant #2 fell backwards. Staff B reported the tenant did not hit her head. After the fall the tenant was unresponsive. When turned on her side the tenant began seizing.

A progress note written by Staff D dated 8/30/22 revealed Staff B walked the tenant towards the dining room. The tenant fell backwards. Vitals were taken and she was assisted off the ground. Additional progress notes documented vitals on 8/30/22 and 8/31/22, A note on 9/02/22 documented Tenant #2 had a fever. No additional notes regarding Tenant #2's condition were documented until a note on 9/6/22 documented Tenant #2 passed and Hospice was notified.

When interviewed on 11/08/22 at 2:27 p.m. Staff B confirmed Tenant #2 fell backwards while ambulating to the dining room to eat breakfast. Staff B reported she walked along Tenant #2's right side towards the dining room while carrying a laundry basket in her right hand. The tenant ambulated fine using her walker with no complaints of discomfort, shortness of breath, or dizziness when she suddenly fell backwards for no known reason. Staff B confirmed she did not have her hands on Tenant #2 at the time, but had provided stand by assistance during ambulation as required by her service plan. She stated the tenant hit her head when she fell. She did not believe she told Staff D, who was in charge at the time and documented the fall on an incident report and in the progress notes. During a follow-up interview on 11/10/22 at 1:16 p.m., Staff B explained "one person assist" with ambulation as noted in Tenant #2's service plan, meant

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having a staff person with her when ambulating. If she were to become unsteady, the staff person was there to help her. A gait belt was not required for Tenant #2.
During a follow up interview on 3/20/23 at 2:07 p.m., Staff B reported she told Staff D Tenant #2 hit her head. Staff B reported she also told the Registered nurse Coordinator (RNC) on the telephone, as well as two other staff present - Staff C and Staff E, as they stood there at the same time she informed Staff D. She reported it was a group call. Staff B reported Nursing Assistants are not to complete incident reports, it was the responsibility of Staff D at the time. Staff B reported she also told Tenant #2's daughters she hit her head when she fell.

Record review failed to produce Staff B's original written statement regarding the event. When the statement was requested on 2/10/23, the facility could not produce the statement and Staff B wrote a new statement. Review of this statement revealed on 8/30/22 she walked with the tenant to the dining room with her hand on the tenant's back. She removed her hand for two seconds and the tenant fell backwards hitting her head on the floor. Staff B called for help and two additional staff arrived.

Interview with Staff D on 11/8/22 at 1:51 p.m. confirmed Staff B told her Tenant #2 did not hit her
head when she fell. During a follow up interview with Staff D on 3/21/23 at 11:12 a.m. she reported she believed Tenant #2 hit her head, regardless of the fact Staff B reported she did not.

When interviewed on 3/21/23 at 7:57 a.m. Staff E stated Staff B reported Tenant #2 did not hit her head following her fall on the morning of 8/30/22.

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A 160	Continued From page 4 When interviewed on 11/8/22 at 3:29 p.m. Staff C reported Staff B noted Tenant #2 did not hit her head when she fell. She stated staff had a difficult time believing this based on the way Tenant #2 laid following the fall. Additional record review on 11/10/22 revealed Tenant #2 was admitted to the Program on 4/15/22 with a diagnosis of end stage Alzheimer's dementia with Lewy body. Her service plan dated 7/14/22 indicated Tenant #2 required her walker and the assistance of one when up and ambulating. Record review revealed a staff delegation form documented training on monitoring of falls involving the head. The document instructed staff to notify the Registered Nurse Coordinator of all falls involving a blow to the head. The delegation directed the following when it was believed a tenant hit their head: obtain a full set of vitals immediately and follow up every shift for the first 48 hours; watch the tenant for increased confusion, excessive sleepiness, headaches, nausea and/or vomiting; notify the RNC of all findings; document all findings in the progress notes and on the incident report. Staff B signed the form 12/29/21, indicating she received the training. Continued record review revealed the Program's policy regarding medication and nursing directed, "... If a (staff) reports a fall or other incident that includes a resident striking their head... the RN in charge will be notified immediately.... the employee will implement the protocols outlined in the Nurse Delegation for Possible Head Injuries..."	A 160		

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When interviewed on 3/23/23 Tenant #2's Daughter stated on 8/30/22 she received a call from her sister regarding a fall her mother sustained. Her mother was unresponsive, but vitals were ok. Upon her sister's arrival to the Program, her mother was having seizures. They had just completed hospice paperwork the day prior. She arrived at the Program a short time later and she and her sister spoke to Staff B, who reported to them their mother had fallen and hit her head. She reported the Hospice Nurse expressed concern regarding a possible brain bleed. They did not take their mother to the hospital since she began hospice that morning. Tenant #2's daughter explained her mother began to have seizures lasting at least two minutes each, several times an hour, for about four hours. Hospice obtained medication for the seizures and morphine for the pain.

When interviewed on 3/23/23 at 4:15 p.m. Tenant #2's POA/Daughter #2 reported she was contacted by the Program at 7:40 a.m. on 8/30/22. The Registered Nurse Coordinator (RNC) informed her her mother had fallen and was unresponsive, though there was no mention of her hitting her head. When she arrived at the Program, her mother was in her room alone. When she asked her mother if she was in pain, her mother began pounding her chest with her hands. Tenant #2's Daughter #2 reported the morning of the incident, Staff B told her and her sister while walking with her mother, she fell straight back and hit her head.

When interviewed on 3/21/23 at 3:52 p.m. the Hospice Nurse confirmed when she arrived at the Program the morning of 8/30/22 both of Tenant #2's daughters were aware she had fallen and hit her head. The hospice nurse reported she

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ensured the daughters did not want to have their mother evaluated in the emergency department, as she could have a brain bleed. She stated the daughters felt she had a poor quality of life and was "ready to go".

When interviewed on 3/20/23 at 11:55 a.m. the Program Director stated she was not present at the Program when the fall occurred. She was not notified of Tenant #2's fall that day. The RNC reported to her via text message on 8/30/22 that Tenant #2 was having seizures, with no mention of a prior fall.

When interviewed on 11/10/22 at 2:59 p.m. the Registered Nurse Coordinator (RNC) confirmed the family chose not to send the tenant to the ER as she was to meet with hospice that same day. The RNC stated she was not made aware of the fact Tenant #2 hit her head until reported to her by the tenant's daughter after the tenant had passed away. The daughter stated she had learned her mother hit her head from Staff B sometime after her mother's death.

In summary, Program staff failed to provide adequate information to ensure appropriate care was received following a fall. When interviewed Staff B reported Tenant #2 hit her head when she fell on 8/30/22. Additional interviews revealed she shared the same information with the tenant's daughters. However, the incident report for the incident indicated the tenant did not hit her head, though a statement from Staff B at the time of the incident was not provided. Staff C,Staff D and Staff E confirmed Staff B reported the tenant did not hit her head when she fell. A statement written by Staff B 2/10/23 indicated the tenant did hit her head when she fell. The RNC and Program Director were unaware Tenant #2 hit her

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A 160	Continued From page 7 head until after the tenant passed.	A 160		