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

2/26/14 mw

PRINTED: 02/17/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		165350	A. BUILDING B. WING		C 02/03/2014
NAME OF PROVIDER OR SUPPLIER FOUNTAIN WEST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 1501 OFFICE PARK ROAD WEST DES MOINES, IA 50265	
(X4) ID PREFIX TAG				PROVIDER'S PLAN DF CORF X (EACH CORRECTIVE ACTION S CRDSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
F 000	INITIAL COMMEN	TS	FO	000	
	investigation of co	ciency relates to the mplaint # 46774 conducted nrough February 3, 2014.	 	See attached PD	ر د.
	(See the code of Federal Regulations (42) CFR, Part 483, subpart B-C). 483,25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING		 F3	609	
24/14	provide the necess or maintain the hig mental, and psych	st receive and the facility must sary care and services to attain thest practicable physical, osocial well-being, in the comprehensive assessment	 		
6.	by: Based on clinical interview, the facil ordered by the phy	ENT is not met as evidenced record review, and staff ity failed to monitor weights as ysician for one of five resident at #3). The facility reported a idents.			
	Findings include:				i
	documented Resid	sion Sheet dated 01/31/14 dent #3 had diagnoses that octure and unspecified anemia.			
		dwritten weight gains/losses the facility identified Resident oss.			
:	The facility Weigh	t Summary Reports			1
LABORATOR	Y DIRECTOR'S OR PROV	IOER/SUPPLIER REPRESENTATIVE'S SIG	SNATURÉ	TITLE	(X6) DATE

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.

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STATEMENT DF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	(X3) DATE SURVEY COMPLETED	
165350		B. WING			C 02/03/2014		
NAME OF PROVIDER OR SUPPLIER FOUNTAIN WEST HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP C 1501 OFFICE PARK ROAD WEST DES MOINES, IA 50265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE	
F 309	Continued From page 1 documented Resident #'3's weights as follows: a. Week of 11/09/13, 131.5 pounds (lb). b. Week of 12/17/13, 137.7 lb. c. Week of 12/31/13, 125.3 lbs. a weight loss of 12.4 pound, 5% weight loss in 30 days. The Weight Summary Report for the week ending 1/30/14, documented the resident's weight 121.9 for the week of 1/9/14, a weight loss of 10%. Record review revealed a physician order sheet dated 1/10/14 that directed staff as follows: weight resident weekly times 4, if stable, bi-monthly weights for one month, if stable monthly weights. The resident's care plan dated 1/12/2014 documented Resident #3 had an alteration in nutrition status, as evidenced by: a. leaves 25% food. b. weight loss. c. therapeutic diet. The care plan directed certified nurse's aides to weight resident as ordered. On 1/27/14 at 2:50 p.m., the facility Director of Nursing (DON) reported no other weights		 	309			
F 353 SS=D	documentation the Resident's #3's we 483.30(a) SUFFIC PER CARE PLAN The facility must h provide nursing ar	a.m., the DON reported no facility notified the physician of eight loss until 1/13/14. IENT 24-HR NURSING STAFF S ave sufficient nursing staff to de related services to attain or est practicable physical, mental,	 F 	353			
	<u> </u>		<u> </u>	<u></u>		<u></u>	

		AND HUMAN SERVICES				FORM A	02/17/2014 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		165350	B. WING	3		1	3/2014
NAME OF P	ROVIDER DR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	,	
FOUNTAIN WEST HEALTH CENTER				1	1501 OFFICE PARK ROAD WEST DES MOINES, IA 50265		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	έlΧ	PROVIDER'S PLAN OF CDRRECTID (EACH CORRECTIVE ACTION SHOULD CRDSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE ,	(X5) COMPLETION DATE
F 353	determined by resignative individual plans of a control of the facility must produce the facility must produce on a 24-care to all residents care plans: Except when waive section, licensed in personnel. Except when waive section, the facility	vell-being of each resident, as dent assessments and	F F	353			
į	by: Based on clinical interview the facilit lights within fifteen residents reviewed reported a census Finding include: 1. The facility ider interviewable. The documented the residents and th	ntified Resident #3 as MDS dated 11/14/13 esident's BIMS (Brief Interview score 13, indicating the					
	During an intention	v on 1/23/14 at 8:58 a m			,		I

Resident #3 reported it took staff "too long to answer" the call lights. The resident reported it

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	ADD ADD OF CHARLED	165350	B. WING		TREET ADDRESS CITY STATE 7ID CORE	02/0	03/2014	
NAME OF PROVIDER OR SUPPLIER FOUNTAIN WEST HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1501 OFFICE PARK ROAD WEST DES MOINES, 1A 50265					
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F 353	2. The facility ident interviewable. The resident's BIMS so impairment. The National frequently incontined on 1/22/14, at 10:7 he/she had soiled to while waiting for state of the resident's BIMS so During an interview Resident #1 reports 50 minutes to answere ported the longe occurred some time the call light response.	age 3 If staff to respond to the call iffied Resident #4 as In 11/7/13 MDS documented the ore 12, mild cognitive MDS indicated the resident ent of both bowel and bladder. 10 a.m., Resident #4 reported him/herself more than once aff to respond to the call light. It ified Resident #1 as In 1/7/13 MDS documented the ore 15, fully cognitively intact. If on 1/27/14 at 11:15 a.m., and it often took staff as long as were the call lights. The resident st wait over an hour had be ago. The resident reported inse time the longest on shifts, as well as the		353				
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PRINTED: 02/17/2014 FORM APPROVED DEPARTMENT OF INSPECTIONS AND APPEALS STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IA0608 02/03/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1501 OFFICE PARK ROAD FOUNTAIN WEST HEALTH CENTER WEST DES MOINES, IA 50265 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 101 50.7(1) 481-50.7 (10A, 135C) Additional N 101 notification. 481-50.7 (10A,135C) Additional notification. The director or the director 's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(1) Of any accident causing major injury. a. " Major injury " shall be defined as any injury. which: Results in death; or (2) Requires admission to a higher level of care for treatment, other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a injury" based upon the circumstances of the accident, the previous functional ability of the resident, and the resident 's prognosis. b. The following are not reportable accidents: (1) An ambulatory resident, as defined in rules 481-57.1(135C), 481-58.1(135C), and 481-63.1(135C), who falls when neither the facility nor its employees have culpability related to the fall, even if the resident sustains a major injury; or (2) Spontaneous fractures; or (3) Hairline fractures.

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

observation, and resident and staff interviews, the

This Statute is not met as evidenced by: Based on record and document review.

facility failed to report a major injury which

TITLE

(X6) DATE

FORM APPROVED DEPARTMENT OF INSPECTIONS AND APPEALS STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 1A0608 02/03/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1501 OFFICE PARK ROAD FOUNTAIN WEST HEALTH CENTER WEST DES MOINES, IA 50265 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION). TAG TAG DEFICIENCY) N 101 N 101 Continued From page 1 required an admission to a higher level of care for 1 of 5 residents reviewed. Resident # 3 fell and sustained a right hip fracture on 12/11/13 and required admission to a hospital and surgery. The facility reported a census of 100 residents. Findings include: Review of the Admission Record document dated 1/31/14, identified Resident # 3 had diagnoses which included a femur fracture and unspecified anemia. The Minimum Data Set (MDS) assessment, with a reference date of 11/14/13. reflected Resident #3 could transfer independently but no longer walked and needed the limited assistance of one staff member to locomote (move from one location to another). The resident used a wheelchair. Additionally, the resident's BIMS (Brief Interview for Mental Status) score was 13. A score of 13 identified the resident as mildly cognitively impaired. Resident # 3's 12/11/2013 3:43 a.m. Progress Notes documented the staff found Resident #3 lying on the room floor with the his/her left leg extended (straight) and the resident's right legbent. The resident was yelling out in pain. The resident was independent with the assist of a wheelchair. Review of the Progress Note dated 12/11/13 at 8:50 a.m. reflected. Resident # 3 was admitted to the hospital with a peri-prosthetic (around the replaced hip joint) fracture of the right femur. The 12/16/13 hospital Physician Discharge Summary

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

fracture).

revealed Resident #3 was admitted and discharged with a closed right peri-prosthetic fracture. The resident had an ORIF (open reduction, internal fixation- surgical repair of a

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FORM APPROVED DEPARTMENT OF INSPECTIONS AND APPEALS STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING **IA0608** 02/03/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1501 OFFICE PARK ROAD FOUNTAIN WEST HEALTH CENTER WEST DES MOINES, IA 50265 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 101 Continued From page 2 N 101 On 1/23/14, at 8:58 a.m., Resident # 3 stated she/he did not remember the circumstances of the fall. On 1/27/14, at 3:35 p.m., observation revealed Resident #3 sitting in his/her wheelchair. The chair had antiroll bars present. During an interview on 1/27/14, at 1:45 p.m., the facility Director of Nursing (DON) stated the facility did not report Resident # 3's 12/11/13 fall to the Department since the resident was independent in their room at the time of the fall. On 1/28/14, at 8:45 a.m., the DON reported the facility had not completed an incident report since the resident was sent to the hospital.

DIVISION OF HEALTH FACILITIES - STATE OF IOWA STATE FORM

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F353 Sufficient 24-Hours Nursing Staff per Care Plans

Call light audits have been initiated as of 2/24/2014. Call light audits will be done randomly by DON, ADON, Patient Care Managers, Charge Nurses, and the Administrator. Audits will be done randomly on all shifts including weekends, monitoring the time that the call light was activated and what time it was responded to. If call light time exceeds the 15 minute rule review of call light response time will be done with staff member.

Call light audits will be reviewed on a monthly basis by Director of Nursing during QA meetings.

F309 Provide Care/Services for Highest Well Being

Resident #3 was monitored and evaluated and no ill effects noted from potential weight loss.

Scales have been re-calibrated by maintenance department on 2/15/14. Scales will be calibrated monthly by maintenance department as part of QA review.

Weights will be reviewed by dietician (case managers in absence of dietician) on days that weights are obtained. If discrepancy noted in weights a re-weigh will be done the next day to verify accuracy of weight. Physician will be notified within 24 hours of significant weight change.

All weight orders received to be noted and noted by 2 nurses. All order changes in regards to weight should be given restorative aide responsible for obtaining weights.

481-50.7 (10A, 135C) Additional notification

Requirements for reporting accidents and major injuries were reviewed with Director of Nursing by the Administrator on 2/12/2014.

When accident or injury occurs, the "Accident/Fall Reporting" flow sheet will be reviewed by Administrator and Director of Nursing. The facility will communicate with designated program chair if unsure of need to report incident. If program chair is unavailable, facility will report accident/injury to DIA.