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FORM APPROVED
OMB NO. 0938-0391

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

7/25/16 PG.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. BUILDING _____ B. WING _____	C 06/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB	4911 SW 19TH STREET DES MOINES, IA 50315

(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: 7-18-16 The following deficincies were identified during the onsite investigation of complaint #59447-C, #60269-C, and #60293-C conducted on June 9-21, 2016. Complaint #60293 substantiated with the following deficiencies. Complaints # 59447-C and #60269 were unsubstantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it. This constitutes my credible allegation of compliance as of July 18, 2016.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157	F157 The standard of Fleur Heights Center for Wellness and Rehab to provide proper notification to Residents, legal representation, and resident attending physician in any changes in treatment, condition, room changes, etc. 1. Mini in-service was completed on 7/18/2016 in review of policy regarding notification of families and attending physician. Upon worsening of wound condition, emergency room visit, or change in treatment. The Director of Nursing or Unit Managers will randomly review nurses notes, incident reports, skin sheets, and other documentation to ensure that proper notification is given.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Hel RN — TITLE: RDN — (X6) DATE: 07/25/2016

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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FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB	4911 SW 19TH STREET DES MOINES, IA 50315

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F 157	Continued From page 1 or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews the facility failed to notify a responsible family member when Resident #4 experienced a change in condition related to the deterioration of a pressure ulcer. The resident sample was five residents and facility census was 103 residents. Findings include: Resident #4 had a quarterly Minimum Data Set (MDS) assessment dated 4/23/16 which revealed the resident had an intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 points. The resident required limited to extensive assistance from staff for activities of daily living including bed mobility, ambulation, hygiene cares, and toileting. The MDS identified diagnoses included Alzheimer's Disease and muscle weakness, and polyosteoarthritis. The plan of care noted resident #4 had an impaired decision making ability related to Alzheimer's disease diagnosis and staff was instructed to encourage the resident to make	F 157	Any issues will be addressed through the quarterly CQI process. **Completion Date: July 18, 2016**	

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F 157	Continued From page 2 independent decisions as long as appropriate and to encourage family to be active with cares and decision making as they are able. Review of Resident #4's individual Wound/Skin Healing record dated 4/25/16 revealed the identification of a stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough and may present as an intact or ruptured blister) on the left heel. The following entries were documented on the record and revealed the family was not notified of the deterioration of the wound: 4/25/16- left heel wound measured 1.5 centimeters (cm) by 1.3 cm with scant drainage. Treatment was Triple Antibiotic ointment and the resident was not to wear shoes. The family and physician were notified. 5/2/16- wound measured 1.7 cm by 2 cm and was covered with eschar (dead tissue resembling a scab) and was deteriorating. Treatment changed to Betadine (broad spectrum antiseptic for topical application in the treatment and prevention of infection in wounds) application. 5/9/16- wound measured 3.2 cm by 4 cm and continued to deteriorate. Treatment apply heel lift boot to left heel. 5/16/16- wound measured 4.5 cm by 5.5 cm and had drainage and a foul odor. The wound continued to deteriorate. The wound record reflected the family was not notified of the deterioration of the wound on the left heel. Nurse's Notes Documentation revealed the following entries: Tuesday 5/17/16 at 2:15 AM - the wound had significantly increased in size, was dark purple in	F 157		

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F 157	Continued From page 3 color, and had a distinct odor present. The documentation did not state the physician and/or family were notified of the change in the wound. Clinical record review of Resident #4's chart revealed the resident experienced an elevated temperature of 101 degrees on 5/13/16 prior to the 5/19/16 diagnosis of osteomyelitis. On 5/14/16 his/her temperature was documented as 99.1 degrees and on 5/17/16 as 99.6 degrees. Documentation did not reveal the family or the physician was notified of the resident's fever. During an interview with family members of Resident #4 on 6/16/16 at 1:00 PM in the resident's room one member stated he/she visits the resident at least twice a week or more. He/she recalled family was notified when the left heel ulcer was first identified on 4/25/16. The family member stated when visiting the resident he/she noted the blue boot on the left foot was not placed correctly. The resident's left heel was not centered in the open depression at the heel of the boot but was pressing on the padding above the hole. He/she stated he/she notified staff of this however when the member returned again to visit the boot still was not on correctly. The family member stated he/she did not see the resident's heels floated on pillows when in bed. The member stated the family was shocked when the resident was diagnosed with osteomyelitis (infection of the bone at the site of the ulcer) during evaluation in the emergency room on 5/19/16. The family member stated the family thought the facility was updating them on changes in the resident's condition but were not notified of the wound deterioration, the resident's fever on 5/13/16, or the identification of a skin issue on the resident's buttocks on 5/19/16.	F 157		

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F 157	Continued From page 4 On 6/16/16 at 1 PM Resident #4 observed to be sleeping in a supine position in bed while the family interview was taking place. The Prafo suspension boots were noted to be on both of the resident's feet and the family members approved of the boots used now. The resident's calves were supported by pillows at this time. During an interview with the Director of Nursing (DON) on 6/15/16 at 9:00 AM she stated staff should notify family members when a resident experiences a change in condition such as deterioration of wounds, change in physician orders, and significant changes in vitals signs such as a fever. She stated she will be re-educating staff on family notification as well as other policies/procedures.	F 157		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical chart review, staff and resident interview, and policy review the facility failed to ensure that a resident entering the facility without pressure sores did not develop	F 314	F314 The standard of Fleur Heights Center for Wellness and Rehab is to ensure that preventative measures are put in place to prevent pressures sores on residents admitted into the facility. 1. Staff A and nursing staff have been reeducated on proper infection control by a mini in-service completed 7/18/2016. Focusing on use of barriers on supplies to prevent contamination and handwashing/gloving.	

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F 314	Continued From page 5 pressure sores unless the individual's clinical condition demonstrated that they were unavoidable. Concerns were noted for three out of four sampled residents with pressure sores (Residents #2, #3, and #4). Appropriate physician ordered wound care was not provided for Resident #4 and Resident #2 and proper infection control techniques were not implemented during wound cares for Resident #4 and Resident #3. Staff did not provide appropriate intervention consistently for these residents. The facility reported census was 103 residents. Findings include: 1. A quarterly Minimum Data Set (MDS) assessment revealed Resident #4 had an intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 14/15 points. Resident #4 required limited-extensive assistance from staff for all activities of daily living including bed mobility, ambulation, hygiene cares, and toileting. The MDS diagnoses included Alzheimer's disease, muscle weakness, and polyosteoarthritis which resulted in bilateral shoulder pain. The MDS noted the resident did not have any pressure, venous, or arterial ulcers at the time of the assessment. The preventive items listed in the MDS Skin and Treatment Section noted a pressure reducing device for the chair and bed was provided for the resident and treatments included application of non-surgical dressings and ointments/medications other than to feet. The MDS reflected the resident was not on a turning or repositioning program or nutritional supplements aimed at prevention of skin issues.	F 314	2. Director of Nursing has meeting on 7/28/2016 with Unity Point Director of Operations for the Wound Center to develop and set up training for Staff A. Staff A will be sent to a wound conference in Des Moines in September. 3. Mini in-service completed with nursing staff reeducating them on skin policy and interventions to prevent skin breakdown done on 7/18/2016. 4. Mini in-service completed on 7/18/2016 regarding removal of discontinued orders on MARs and TARs. Wound care audits will be done with all facility nurses. Audits on Nurses will be conducted and Nurses will continue to be audited on a quarterly basis. All residents with wounds will be reviewed weekly during ICF meeting. Any patterns or issues with wounds will be reviewed at the quarterly CQI meeting Completion Date: July 18, 2016	

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F 314	Continued From page 6 The Braden Scale (pressure sore risk assessment) is performed on all residents quarterly (every three months) to tract resident risk of developing pressure ulcers. The Braden scores for Resident #4 on 8/28/15, 11/6/15, and 4/25/16 were "15". Staff neglected to document findings for an assessment due in February of 2016. The scale for the Braden scores is as follows: <9 =very high risk 10-12= high risk 13-14= moderate risk 15-18= at risk The plan of care noted Resident #4 had a self-care deficit related to Alzheimer's disease and decreased functional mobility. The interventions to prevent skin issues were initiated on 8/7/15 and staff was instructed to consult the wound nurse as needed, to float heels off the bed as requested, and to provide pressure relieving mattress and chair cushion. After identification of a pressure ulcer on the resident's heel on 4/25/16, "float heels" was written on the care plan. After identification of a second pressure ulcer on the resident's right heel on 6/6/16, "Prafo boots" (boot device that is worn on the calf and foot and is often used for patients to relieve pressure on the heel and prevent pressure ulcers) were implemented for the resident. Review of individual Wound/Skin Healing record for Resident #4 dated 4/25/16 revealed the identification of a stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough and may present as an intact or ruptured	F 314		

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F 314	Continued From page 7 blister) on the left heel. The following entries were documented on the record: On 4/25/16- left heel wound measured 1.5 centimeters (cm) by 1.3 cm with scant drainage. Treatment was Triple Antibiotic ointment and the resident was not to wear shoes. On 5/2/16- wound measured 1.7 cm by 2 cm and was covered with eschar (dead tissue resembling a scab) and was deteriorating. Treatment changed to Betadine (broad spectrum antiseptic for topical application in the treatment and prevention of infection in wounds) application. On 5/9/16- wound measured 3.2 cm by 4 cm and continued to deteriorate. Treatment apply heel lift boot to left heel. On 5/16/16- wound measured 4.5 cm by 5.5 cm and had drainage and a foul odor. The wound continued to deteriorate. Nurse's Notes Documentation revealed the following entries: On 5/17/16 (Tuesday) at 2:15 AM - the wound had significantly increased in size, was dark purple in color, and had a distinct odor present. The resident had been asked how his/her left heel felt and stated the heel did not hurt. The documentation did not state the physician had been notified of the change in the wound. On 5/19/16 (Thursday) at 5:30 AM - a new superficial open area with scant drainage was identified by staff on the resident's buttock. The area was cleansed and dried and left open to air. The doctor was notified and treatment orders were received. On 5/19/16 at 9:00 AM - the resident's left heel had deteriorated since 5/16/16 (Monday) and now had a foul odor and a brownish serosanquinous (fluid leaving a wound that is yellowish with small amounts of blood) drainage.	F 314		

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F 314	Continued From page 8 Notification of the family was documented at this time. On 5/19/16 at 1:00 PM - the Advanced Registered Nurse Practitioner (ARNP) examined the heel wound,and Resident #4 was sent to the emergency room for evaluation of the left heel pressure ulcer. On 5/19/16, a physician ' s order for pre-albumin and wound culture to left heel was ordered. Record review of hospital Progress Notes dated 5/27/16 revealed the resident was admitted on 5/19/16 due to left heel wound which had been present for at least 3 weeks. Apparently a piece of tissue had fallen out of the wound which concerned staff. The resident had been complaining of a low grade fever. The reported identified a diagnosis of left calcaneal (heel bone) osteomyilitis (bone infection) and heel ulcer with necrosis (dead tissue). On examination the area was covered with black eschar but this was boggy and there was drainage and an odor. The resident reported pain in his/her left leg. The resident had a debridement (surgical removal nonliving tissue from pressure ulcers) while a patient in the hospital. Nurse's Notes Documentation revealed the following entries: On 5/27/16 at 1:45 PM - the resident returned to the facility and was admitted for skilled care. On 5/30/16 at 9:30 AM - the family noticed a new lesion on Resident #4's right heel and notified the staff. Review of an Individual Non-Pressure Skin Condition Record for Resident #4 dated 5/30/16 documentation revealed a 3 cm by 5 cm area	F 314		

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F 314	Continued From page 9 located on the right heel which appears to have dark fluid visible under intact skin. Review of individual Wound/Skin Healing Record dated 5/31/16 revealed the wound was unstageable and covered with eschar. The wound when opened, measured 3.5 cm by 2 cm. During observation of wound care for Resident #4 on 6/10/16 at 8:40 AM Staff A, Registered Nurse (RN), gathered supplies including tape, an unwrapped roll of gauze, a wrapped dressing, and a paper tape measure and placed the supplies on her clipboard. The top page on the clip board had Staff A's written notes on it. She entered the resident's room, placed the clipboard with supplies on a bedside table, washed her hands, and donned gloves. The Director of Nursing (DON) was in the room to observe the procedure. Staff A poked the wound bed with her gloved finger to check the surface of the ulcer on the right heel. The wound bed appeared to be slough tissue with a dark pink area surrounding the wound bed. A scant amount of serosanguinous drainage was noted. Staff A measured the wound with the paper tape (6 cm by 2.2 cm), soaked a square of gauze with Betadine, painted (applied) betadine on the wound, and elevated the right heel on a pillow to dry uncovered. Review of Resident #4's Treatment Administration Record (TAR) noted the treatment to the right heel was to cleanse the wound with wound cleanser, pat dry, dry paint with Betadine, and leave open to air once each day. Staff A neglected to clean the wound with wound cleanser prior to painting the heel with betadine and did not change her gloves appropriately	F 314		

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F 314	Continued From page 10 during the procedure. Staff A continued with wound cares (from 6/10/16 at 8:40 a.m.) and washed her hands and changed gloves. She measured the wound on the Resident's left heel which had been debrided previously at the hospital. The wound measured 8 cm by 8 cm with a depth of 0.3 cm. Hard eschar covered the wound base and no drainage or foul odor was noted. She poked on the wound bed with her gloved finger and took Betadine soaked 4 X 4 squares and placed the soaked squares on the wound bed. Securing the soaked 4 X 4 squares to the wound bed she wrapped the wound and 4 X 4 squares with the roll of unwrapped gauze which was still located on the clipboard. The Betadine soaked through the outer wrapping and the wound nurse applied the Prafo lift boot to the foot. Review of Resident #4's TAR noted the treatment to the left heel was to cleanse the wound with wound cleanser, pat dry, dry paint with Betadine, and cover with a dry dressing daily (ordered on 6/2/16). The treatment Staff A performed on the left heel during observation was an old order that had been discontinued on 6/2/16. Staff A again neglected to change her gloves appropriately during the procedure. During an interview with Resident #4 on 6/10/16 at 8:20 AM the resident stated the wound on the left foot became infected when it was "not taken care of" by staff. The resident stated his/her legs were not elevated off the mattress or her recliner footrest previously. He/she stated after the left foot wound was discovered a blue boot was placed on the left foot but not the right foot. The resident stated there now is a wound on the right heel and his/her bottom. The resident stated the	F 314		

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(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 314	Continued From page 11 physician told him/her the wounds were from "pressure". During an interview with Resident #4's primary care physician (PCP) he stated with the resident's current diagnoses he was not surprised the left heel wound deteriorated to a severe state so quickly. When asked about the development of the wound initially he stated the facility staff is going "above and beyond" with the care of the wound but multiple factors are inhibiting wound healing. Nurse's Notes documentation revealed the following entries: On Tuesday 5/17/16 at 2:15 AM - the wound had significantly increased in size, was dark purple in color, and had a distinct odor present. The documentation did not state the physician had been notified of the change in the wound. Clinical record review of Resident #4's chart revealed the resident experienced an elevated temperature of 101 degrees on 5/13/16 prior to the 5/19/16 diagnosis of osteomyelitis. On 5/14/16 his/her temperature was documented as 99.1 degrees and on 5/17/16 as 99.6 degrees. Documentation did not reveal the physician was notified of the resident's fever. During an interview with family members of Resident #4 on 6/16/16 at 1:00 PM in the resident's room one member stated he/she visits the resident at least twice a week or more. He/she recalled family was notified when the left heel ulcer was first identified on 4/25/16. The family member stated when visiting the resident he/she noted the blue boot on the left foot was not placed correctly. The resident's left heel was	F 314		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	165273	A. BUILDING _____ B. WING _____	C 06/21/2016

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F 314	Continued From page 12 not centered in the open depression at the heal of the boot but was pressing on the padding above the hole. He/she stated he/she notified staff of this however when the member returned again to visit the boot still was not on correctly. The family member stated he/she did not see the resident's heels floated on pillows when in bed. The member stated the family was shocked when the resident was diagnosed with osteomyelitis (infection of the bone at the site of the ulcer) during evaluation in the emergency room on 5/19/16. The family member stated the family thought the facility was updating them on changes in the resident ' s condition but were not notified of the wound deterioration, the resident's fever on 5/13/16, or the identification of a skin issue on the resident's buttocks on 5/19/16. The resident was observed to be sleeping in a supine position in bed while the family interview was taking place. The Prafo suspension boots were noted on both feet and the family members approved of the boots used now. The resident's calves were supported by pillows at this time. 2. A quarterly MDS assessment for Resident #2 dated 3/6/16 revealed the resident had an intact cognition as evidenced by a BIMS score of 15/15 points. Resident #2 required limited assistance from staff for all activities of daily living including bed mobility, ambulation, hygiene cares, and toileting. MDS diagnoses included Non-Alzheimer's disease and Diabetes Mellitus. The MDS noted the resident did not have any pressure, venous, or arterial ulcers at the time of the assessment. The preventive items listed in the MDS Skin and Treatment Section noted a pressure reducing device for the chair and bed was provided for the resident and treatments included application of ointments/medications	F 314		

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F 314	Continued From page 13 other than to feet. The MDS reflected the resident was not on a turning or repositioning program or nutritional supplements aimed at prevention of skin issues. The plan of care noted Resident #2 had a self-care deficit and required assist of staff for bed mobility and ambulation. Interventions to prevent skin issues were initiated on 12/18/15 and staff was instructed to consult the wound nurse as needed, float heels off the bed as tolerated, to provide pressure relieving mattress and chair cushion. After identification of a pressure ulcer on the resident ' s left heel on 3/26/16 " Heel-lift boots to be worn at all times-may remove for cares. Will refuse, was hand written on the care plan. The Braden scores for Resident #2 on 3/10/16 was "18" and on 6/7/16 was "17" indicating the resident was at risk for developing pressure ulcers Review of Resident #2's Wound/Skin Healing record dated 3/28/16 revealed the identification of a stage two pressure ulcer located on the left heel. The wound measured 2.1 cm by 2.3 cm with a depth of 0.2 cm and was noted to have purulent drainage (drainage consisting of pus). A second wound was identified on 4/11/16 on the medial aspect of the resident's left foot measuring 2 cm by 4 cm and was unstageable. Records revealed this wound was healed on 5/16/16. During observation of wound care for Resident #2 on 6/15/16 at 11:20 AM with the Director Of Nursing (DON) in the room to observe also, Staff B, Licensed Practical Nurse (LPN), gathered supplies, entered the resident's room, and placed	F 314		

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F 314	Continued From page 14 the supplies on a clean barrier. Staff C, LPN, removed the resident's sock from the left foot and it was noted there was no dressing covering the wound. The resident stated at this time he/she had a shower last evening and staff did not re-dress the wound. The wound had a scant amount of drainage from the wound bed. Staff B provided appropriate wound care for the resident and maintained adequate infection control techniques. Review of Resident #2's TAR noted the treatment to the left heel was to cleanse the wound with wound cleanser, apply Aquacell AG (antimicrobial dressing) , and wrap with Kerlix (gauze wrap). Nursing staff neglected to provide appropriate wound treatment for the resident after the resident's shower on 6/14/16. 3. Resident #3 had a quarterly Minimum Data Set (MDS) assessment, dated 5/16/16, which revealed the resident had an intact cognition as evidenced by a BIMS score of 15/15 points. The MDS assessed the resident as independent with all activities of daily living except toileting. MDS diagnoses included heart failure and obesity. The MDS noted the resident did not have any pressure, venous, or arterial ulcers at the time of the assessment. The MDS identified the resident at risk of developing pressure ulcers. The preventive items listed in the MDS Skin and Treatment Section noted a pressure reducing device for the chair and bed was provided for the resident and treatments included application of ointments/medications other than to feet. The care plan noted the method of ambulation and transfer was changed to staff assist with the	F 314		

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F 314	Continued From page 15 mechanical Easy-Stand lift stand on 5/19/16. After identification of unstageable ulcer to the left heel on 6/5/16 "Heel-lift boots, Arginine (wound healing supplement) and Multi-vitamin to start "was hand written on the care plan. The Braden scores for Resident #2 on 5/19/16, prior to his/her decline, was "20" indicating the resident was not at risk for developing pressure ulcers. Review of Resident #3's Wound/Skin Healing record dated 6/5/16 revealed the identification of an unstageable pressure ulcer located on the left heel. The wound measured 4.8 cm by 8.3 cm with an open area of 4.8 cm by 4.5 cm.. A moderate amount of serosanquinous drainage was documented. The record reflected Prafo boots were ordered for the resident. Observation on 6/10/16 at 8:00 AM revealed Resident #3 seated in a wheelchair in his/her room. The resident's feet were uncovered. The left foot had a dressing over the heel and the dressed heel was resting on the floor without a barrier. During observation 6/10/16 at 9 AM Staff A, RN, placed dressing supplies (unwrapped roll of gauze, 4 X 4 gauze squares sprayed with wound cleanser, and tape measure) on the clipboard and entered Resident #3's room to provide wound care. Resident #3 was seated in a wheelchair with his feet on the floor. Staff A noted the resident's feet did not have blue boots on and stated the resident was to wear the heel-lift blue boots at all times. Staff A washed her hands and gloved. She took the old dressing off the resident's heel and changed her gloves. The	F 314		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 16 DON, present to observe the procedure, held the resident's leg up off the floor for Staff A to measure the wound (8.3 cm by 4.8 cm with a slough/eschar wound base measuring 4.5 cm by 4.8 cm). Staff A washed the wound with wound cleanser and took a Telfa (non-stick) dressing out of the package. She placed the clean dressing directly on the floor and placed the resident's foot onto the dressing. She picked up the Telfa dressing and heel and wrapped the foot with the gauze roll. Staff A did not apply Santyl ointment to the resident's wound and stated she would call the physician to ask if the Santyl should be continued since the wound was no longer completely covered with eschar. Review of Resident #3's TAR noted the treatment to the left heel was to cleanse the wound with wound cleanser, pat dry, apply Santyl, cover with dry dressing, and wrap with gauze twice daily and as needed. The TAR noted the resident was to float heels when in bed. The TAR did not instruct staff to place heel lift boots on the resident as noted the care plan. Review of a Physician Progress Note dated 6/10/16 revealed the physician diagnosed the wound as a left heel ulcer with cellulitis. The resident was placed on Rocephin (antibiotic) - intramuscular injection daily for seven days. During an interview with Resident #3 on 6/10/16 at 9:15 AM the resident stated it was his/her understanding that the boots were to be on all the time. He/she stated staff did put the boots on last night. This morning when he/she was assisted to get up staff did not put socks or the boots on his/her feet and he neglected to tell them to.	F 314		

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F 314	Continued From page 17 Observation of Resident #3 on 6/15/16 at 10:30 AM revealed the resident asleep in the wheelchair without boots on his/her fee which rested on the floor. Observation of Resident #3 on 6/16/16 at 9:00 AM revealed the resident asleep in the wheelchair with blue boots on both feet. Observation of Resident #3 on 6/17/16 at 9:20 AM revealed the resident asleep in the wheelchair without boots on his/her feet which rested on the foot pedals of the wheelchair. During an interview with Staff D, MDS/care plan nurse, on 6/15/16 at 10:20 AM she stated on admission all residents who are not independent with ambulation have interventions placed to float heels by placing pillows under their calves when in bed and pressure relieving mattresses and chair cushions. Residents assessed to be high risk for skin issues are placed on air alternating mattresses. The wound nurse, Staff A, then implements other preventative interventions as needed/ordered. During an interview with the Director of Nursing (DON) on 6/15/16 at 9:00 AM she stated all residents have weekly skin checks done by the nurse and on shower/bath days the Certified Nurse's Aides (CNAs) are responsible for checking the resident's skin and reporting to the nurse. The DON agreed that Staff A, Wound Nurse, did not provide the correct treatment for Resident #4's heel wound. She stated Resident #4's left heel treatment had been changed on 6/2/16 and staff neglected to remove the older order from the TAR so two different treatments for the left heel were present on the TAR. She	F 314		

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F 314	Continued From page 18	F 314		

agreed Staff A, did not follow proper infection control techniques while providing wound cares to Resident #4 and Resident #3 and resident #2 should have had a dressing on his/her wound after his/her shower. She stated Staff A was new to the position of wound nurse and had requested additional training for wound care techniques. The DON stated she would arrange additional training for Staff A through the Hospital Wound Clinic. The DON stated she has been at the facility for one month and realizes she has education to provide for staff concerning preventative pressure ulcer interventions such as consistent heel floating and application of boots for residents at risk. The DON agreed that all residents should be thoroughly assessed for preventative skin interventions and appropriate interventions should be implemented.

Review of the facility Skin Care and Early Treatment Policy, review date of 1/2013, noted residents who score 13-16 points on the Braden Scale (Resident #4) should have the following interventions placed:
a. heel protectors
b float heels/elbows with pillows
c. weekly skin checks
d. wheel chair cushion
e. possible supplement and vitamin therapy