PRINTED: 07/15/2016

DEMART	MENT OF HEALTH AN	ID HUMAN SERVICES		OMB NO. 0938-0391		
DEPART	e cop Medicade & l	MEDICAID SERVICES		7/25/14 86.	(X3) DATE SURVEY	
CENTER	S FOR MEDICARE &	(X1) PROMOER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION .	COMPU	ETED
SYATEMENT OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING _		1	!
) Allordaro.	and and the state of the state		1		C	
		165273	B. WNG		06/2	1/2016
		1002.1	- 	TREET ADDRESS, CITY, STATE, ZIP CODE		ļ
NAME OF P	ROMDER OR SUPPLIER	•	4	911 SW 19TH STREET	•	
EL ELIO DE	GHTS CENTER FOR W	ELLNESS AND REHAB		ES MOINES, IA 50315		
FLEORIN			 _	MODIAGERS PLAN OF CORRECTION		(XS) COMPLETION
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREFIX	I CARD COORECTOR ACTION SHOULUI	; ⊏	COMPLETION
PREFIX	(EACH DERCIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TAG	OROSS-REFERENCEO TO THE APPROPRI DEFICIENCY)	AIE	İ
TAG	KEROTVICKI OILI		Y	, DETOLETO!		
ļ.——-				· .	1	
1			F 000	•	1	
F 000	INITIAL COMMENTS	i		Preparation and/ or execution of	his plau o	f
	_		1	correction does not constitute ad	niceian Ar	-
	Correction date: 7-	18.76		on the actionation and noncornos	touth of th	ie l
}			1	agreement by the Provider of the	uth in the	`-
	The following deficing	ies were identified during	1	facts alleged or conclusions set fo	ин ш ш	
[the ancite investigation	n of complaint		statement of deficiencies.		į į
	#59447-C, #60269-C	and #60293-C conducted			(3/02	
}	on June 9-21, 2016,		1	The plan of correction is prepared	I and/or	
1			}	executed solely because the provi	sions or	
	Complaint #60293 su	bstantiated with the	1	Federal and State law require it.		
	following deficiencies		[•		
	Complaints # 59447-0	C and #80269 Were	(This constitutes my credible all	gation of	
[]	unsubstantiated.		1	compliance as of July 18, 2016.		. j
[m	1	1		1
1 1	See Code of Federal	Regulations (42CFR) Part	1	F157		
) !	483, Subpart B-C.	A AND OUT OF O	F 167	The standard of Fleur Heights Cen	nter for	
F 157	483.10(b)(11) NOTIF	Y OF CHANGES	}	Wellness and Rehab to provide pr	oper	
SS≒D	(INJURY/DECLINE/R	OOM, ETC)]	notification to Residents, legal		ļ .
		table before the resident:	1	representation, and resident attend	ing	
	A facility must immed consult with the reside	iately inform the resident;	1	physician in any changes in treatn	ent,	
ŀ	CONSUIT WITH THE reside	dent's legal representative		condition, room changes, etc.		1
	Known, notity the resi	y member when there is an	}	Contractor, 2002 2		1
	of all interested terms	resident which results in		 Mini in-service was comp 	leted on	}
	loturi and has the oth	antial for requiring physicials	- [7/18/2016 in review of po	licy	1
	intervention: a signific	soft change in the residence		regarding notification of	amilies	
	introcinal mental, of D	sychosociál álállús (I.e., 2		and attending physician.	Upon	1
	deterioration in health	i, mental, or psychosocial	1	worsening of wound cond	lition.	{
!	etatus in either life thr	eatening conditions or		emetgency room visit, or	change in	
	clinical complications)	r a need to alter treatment		treatment.		1
	eignificantly (i.e., a na	ed to discontinue an		n cannent.		1
	Avieting form of treatm	nent due to adverse	1			1
[consequences, or to o	commence a new form of	1	on minutes of the since on Y built had	anagers	1
[treatment): or a decision	ion to transfer or discharge	- }	The Director of Nursing or Unit M	incident	
}	the resident from the	facility as specified in		will randomly review murses notes,	MOLITARE	}
	§483.12(a).		†	reports, skin sheets, and other	n+	
1		1-17	1	documentation to ensure that prope	ı	1
	The facility must also	promptly notify the resident		notification is given.		ļ
, ,	and, if known, the res	ident's legal representative			, <u>.</u>	
[<u> </u>	MANUAL DE DESERVATURE QUENTILE	_	mie ,		(8) DATE
LABORATORY	DIRECTOR'S OR PROVIDERA	SUPPLIER REPRESENTATIVE'S SIGNATUR	7	$\Lambda \rho \mathcal{N}$	()7/25/2016

Any deficiency statement anding with an asteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sateguards provides profide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the shove findings attaled above are disclosable 14 following the date of survey whether or not a plan of correction is provided. For nursing homes, the shove findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are clied, an approved plan of correction is requisite to continued program participation.

PRINTED: 07/15/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-<u>0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION CONSTELLED IDENTIFICATION NUMBER: A. BUILDING. 06/21/2016 B. WING 185273 STREET ADDRESS, CITY, STAYE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4911 SW 19TH STREET FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB DES MOINES, IA 50315 (XS) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) IO PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LECTIDENTIFYING INFORMATION) DEFICIENCY) Any issues will be addressed through the quarterly CQI process. F 157 Continued From page 1 Completion Date: July 18, 2016 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 bv: 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 dally living including bad mobility, ambulation, hygiene cares, and toileting. The MDS identified diagnoses included Alzhelmer's Disease and muscle weakness, and polyosteoathritis. 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

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES				FORI O <u>MB NO</u>	D: 07/15/2016 MAPPROVED D: 0938-0391
		MEDICAID SERVICES	(Y2) k018	mere	CONSTRUCTION	(X3) DATE	SURVEY
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	'LETED
AND PLAN OF	· GOTUNEO HON	,	12.00.00				c j
	·	165273	B. WING			06/	21 <u>/2016</u>
		01200			TREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROMDER OR SUPPLIER			1	911 SW 19TH STREET		
EL PUID LI	IR HEIGHTS CENTER FOR WELLNESS AND REHAB			1 '	DES MOINES, IA 60315		
LPCOK UI	HOUSE CENTERS OF THE		 —		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	アイタロ かんむかんしんけいい	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E VTE	COMPLÉTION
<u> </u>				_			
			E	157			}
F 157	Continued From page	:2	'	101			
	independent decision:	s as long as appropriate and					
	to encourage family to	be active with cares and	ł				[
	decision making as th	ey are able.	İ		, i		ĺ
		4's individual Wound/Skin]
	Healing record dated	AISTING revealed the	İ]
	Meaning record dated	e Iwo pressure ulcer (partial]		,		
	thinkness less of dem	nis presenting as a shallow					1
	onen uicer with a red-	pink wound bed without	1				}
	clouds and may brese	ent as an intact or ruptured	-				
	bliefor) on the left hee	i. The following entries					
:	were documented on	the record and revealed the	-				}
	family was not notified	of the deterioration of the	-				
	wound:		1				1
	4/25/16- left heel wou	nd measured 1.5	1				
	centimeters (cm) by 1	.3 cm with scant drainage.					1
	Treatment was Triple	Antibiotic ciniment and the	-				\$
	resident was not to We	ear shoes. The family and					
j	physician were notified	red 1.7 cm by 2 cm and					
	9/2/18- Wound measu	har (dead tissue resembling			•		
ļ	a scab) and was deter	iorating. Treatment		:			1
	changed to Betadine (broad spectrum antiseptic					
	for tonical application	in the treatment and					
j	prevention of infection	in wounds) application.	1			İ	}
	FIGHE, wound measu	red 3.2 cm by 4 cm and					·
ł	continued to deteriora	te. Treatment apply heel lift					
ŀ	boot to left heef.		1.				
ļ	5/16/16- wound meas	ured 4.5 cm by 5.5 cm and			'	į	
ļ	had drainage and a fo	ul odor. The wound				İ	
4	continued to deteriora	te. ected the family was not					
1	The Wound record fell	ected the lattiny was not ation of the wound on the					
4		BROW OF RIGHT AND WAS	1				·]
1	left heel.		1				ļ
1	Nurse's Notes Docum	entation revealed the	1			į	1
	following entries:		1			į	1
	Triggday 5/17/16 at 2:	15 AM - the wound had	1			ĺ	ĺ
	cimificantly increased	in size, was dark purple in	1				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB <u>NO. 0938-</u>0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DAYE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 06/21/2016 165273 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4911 SW 19TH STREET FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB DES MOINES, IA 50315 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (CS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 157 Continued From page 3 F 157 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 heaf 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 6/13/16, or the identification of a skin issue on the resident's buttocks on 5/19/16.

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES			FORM OMB NO	: 07/15/2016 APPROVED : 0938-0391
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES	No retaine	LE CONSTRUCTION	(X3) DATE	SURVEY ,
STATEMENT O)f deficiencies	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		COMPL	
AND PLAN OF	CORRECTION	IDEATH WATER TOWNS	- A BONCOING		1 0	;
	İ	4ge/¥3	B. WING		06/2	21/2016
		185273	_ 	STREET ADDRESS, CITY, STATE, ZIP CODE		-
NAME OF PI	RÓVIDER OR SUPPLIER		1	4911 SW 19TH STREET		
ID 116	TOUTO CENTER FOR W	ELLNESS AND REHAB		DES MOINES, IA 50315		
FLEAK HE	FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB			DECLARGOS EL AN DE CORRECTIO	N	(%)
(X4) ID PREFIX TAG	APPROXIMENTAL OF THE PROXIMENT OF THE PR	atement of deficiencies y must be preceded by full .sc identifying information)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIESE DEFICIENCY)	3.86 [CONPLETION DATE
F 157	Continued From page	.4	F 15	7		
F 314 8S=G	sleeping in a supine programity interview was to suspension boots were resident's feet and the of the boots used now were supported by pill. Duting an interview were supported by pill. Duting an interview were supported by pill. Duting an interview were supported by pill. Duting an interview were supported by feet at should notify family mexperhences a change deterioration of wours orders, and significant such as a favor. Share-educating staff on other policies/procedid 483.25(c) TREATME! PREVENT/HEAL PRIME Based on the compression of develop president, the facility method which were unavoidable pressure sores received acrices to promote here the prevent new sores from this REQUIREMENT by: Based on observation and the conditional methods interview.	of the Director of Nursing 9:00 AM she stated staff tembers when a resident of in condition such as de, change in physician of the changes in vitals signs stated she will be family notification as well as ures. NIT/SVCS TO ESSURE SORES Thensive assessment of a must ensure that a resident or without pressure sores assure sores unless the indition demonstrates that the e; and a resident having the estimate of the medical of the content of the condition and the estimate of the content of the condition and the estimate of the content of the condition and the estimate of the condition and the content of the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition and the condition are conditionally the condition and the condition and the condition and the condition are conditionally the condition and the condition and the condition are conditionally the conditional the conditional the conditional the conditional the conditional the conditional the conditional the conditional the conditional the conditional the conditional the conditional the conditional the conditional the conditional the conditional the conditional the conditional three cond	F31	F314 The standard of Pleur Heights Of Wellness and Rehab is to ensure preventative measures are put in prevent pressures sores on residuadmitted into the facility. 1. Staff A and mursing st been reeducated on proinfection control by a reservice completed 7/18 Focusing on use of bar supplies to prevent com and handwashing/glovi	e that n place to— ients aff have oper nini in— t/2016. riers on namination	
	facility without pressu	re sores did not develop			<u></u>	

DEPARTA	MENT OF HEALTHAN	D HUMAN SERVICES				FORM OMB <u>N</u> O	: 07/16/2016 APPROVED : 0938-0391
DENTED	S FOR MEDICARE &	MEDICAID SERVICES			- WYOUGHON	(X3) DATE	SURVEY
CENTER	OF DEFICIENCIES	IN DRAMIENCAUTCHEVVEN	1		CONSTRUCTION	COMP	LETEO
STATEMENT C	CORRECTION	IDENTIFICATION NUMBER:	V BAILO	ING _		1 (; l
***** 12 44 21	•					1 .	21/2016
		165273	a.WNG		THE CARE	1 000	
					TREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PR	ROVIDER OR SUPPLIER				911 SW 19TH STREET		ļ
_, eus uit	TOUTS CENTER FOR W	ELLNESS AND REHAB		l	ES MOINES, IA 50315		
FLEURHE			1	<u> </u>	THE PROPERTY OF CORRECTION	1	COMPLEXYM (xv)
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL , SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCEO TO THE APPROPR DEFICIENCY)	DE I	DATE
F 314 (pressure sores unles condition demonstrat unavoidable. Concer of four sampled residents #2, #3, are physician ordered we for Resident #4 and infection control tech implemented during and Resident #3. Stappropriate intervent residents. The facility residents. Findings include: 1. A quarterly Minimassessment revealed cognition as evidence Mental Status (BIMS Resident #4 requirections staff for all activated in the composition of the control of the cont	s the individual's clinical and that they were and that they were are with pressure sores and #4). Appropriate and care was not provided Resident #2 and proper and cares for Resident #4 and for consistently for these by reported census was 103 are the word of the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistent was 103 are the consistency are the consistency are the consistency was 103 are	F	314	 Director of Nursing has ince 7/28/2016 with Unity Point Director of Operations for the Wound Center to develop an up training for Staff A. Staff will be sent to a wound confin Des Moines in September Mini in-service completed womaning staff reeducating the skin policy and intervention prevent skin breakdown dor 7/18/2016. Mini in-service completed of 7/18/2016 regarding removed discontinued orders on MAI TARs. 	nd set fA ference with em on s to ne on Al of Rs and all	·
	tolleting. The MDS d Alzheimer's disease, polyosteoathrilis whi shoulder pain. The M not have any pressu at the time of the ast items listed in the Mi Section noted a pres chair and bed was p treatments included dressings and ointm to feet. The MDS re	lagnoses included muscle weakness, and ch resulted in bilateral MDS noted the resident did re, venous, or arterial ulcers easement. The preventive DS Skin and Treatment esure reducing device for the roylded for the resident and application of non-surgical ents/medications other than flected the resident was not			facility nurses. Audits on Nurses we conducted and Nurses will continue audited on a quarterly basis. All residents with wounds will be received during ICF meeting. Any patterns or issues with wounds reviewed at the quarterly CQI meet. Completion Date: July 18, 2016	eviewed will be	
1			L_		li eou	ະກິດແລນິວກ ຍ ື່ ກ	cet Page B of 19

	LIENTU	AND HUMAN SERVICES				10 (a) F18Y	O. 0938-0391 E SURVEY		
EPARTM	ENT OF HEALITA	& MEDICAID SERVICES	T	LE CONS	STRUCTION	COM	PLETEO		
ENTERS	FOR MEDICARE	C WALLEST THE THE PROPERTY OF	A, BUILDIN	, , ,		C 06/21/2016_			
O	NEELCIENCIES	IDENTIFICATION NUMBER:	A, BUILDIN	•					
PLAN OF C	CORRECTION	•	B. WHG				JE WEST.		
		166273	1 8' AIRIO	CZDEF	TADORESS, CITY, STATE, ZIP CODE		1		
			- 1	SINCE	W 19TH STREET				
AME OF PR	OVIDER OR SUPPLIER		\	4911 0	NOINES, IA 50315				
	ARNTED FOI	K MELTUESS AND KEHAR		DEST		ON	COMPLETION -		
-LEUR HE	GHIS CENTER OF	- TUDIFO	QL	_ {	PROMDER'S PLAN OF CONTIES. (EACH CORRECTIVE ACTION SHOULD BE APPROXIMATED TO THE APPR	LD BE PRINTE	DAYE		
	SUMMAR	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX	`	(EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE APPRODE TO THE	, 1212			
(X4) ID PREFIX	(EACH DEFICE	ENCY MUST BE PRECEDED BY COMPANY ON OR LSC IDENTIFYING INFORMATION)	17(3		DEFICIENT				
TAG	REGULATOR	QR 100 1			·· ————		1 1		
							1		
			F:	314			1		
F 314	Continued From	page 0		- 1					
• •		/	1	1			Ĭ.		
	assessment) is p	erformed on all residents	[1			į		
	quarterly (every	erformed on all resident three months) to tract resident - pressure picers. The Braden		}			Ì		
	risk of developing	g pressure ulcers. The Braden	1	ł			•		
	scores for Resid	ent #4 on 8/28/15, 11/6/15, and			•		ţ		
	4/25/16 were "1	ent #4 on 8/28/15, 11/5/15, 5". Staff neglected to document	-				1		
	findings for an a	ssessment due in February of	- 1						
	2016. The scal	e for the Braden scores is as	Ì	1			ì		
	follows:		1						
	o =very high ri	sk	1	- 1					
	Haruage bigh risk	<u>(</u>		- 1					
	13-14= modera	te risk	}	1			}		
	15-18= at risk		}	- 1			}		
		ex-sident #A had a	1	1			1		
	The plan of car	e noted Resident #4 had a		1			j		
	self-care deficit	Telaution to the		1			1		
	and decreased	functional mosaling were initiated		1			}		
ì	interventions to	prevent and to consult the		1					
1	on 8/7/15 and	sian was manual heels off the bed	Ì	- 1					
Ì	wound nurse a	and to provide pressure reliaving	Į.	1			1		
1	l	aud fo hiosing to a	1				1		
1	mattress and t	mair Cosmon.							
ļ	-After identifica	lion of a pressure ulcer on the 1 on 4/25/16, "float heels" was							
}	resident's hee	on 4/20/10, however	}				ł		
Į.	written on the	care plan.			}				
ł	After identifica	ation of a second pressure the hoots" along the hoots on the calf and foot and	}		Į.				
	the residents	right free on the calf and foot and	}						
	(boot device t	hat is worth on relieve pressure on	}		{		ľ		
1	is often used	for patienta (o tello compressore ulcers) were	ł				1		
1			}		-	•	1		
1	implemented	for the resident.					ţ		
1	1		\				1		
		dividual Wound/Skin Healing record	1		1		1		
1	Review of inc	fividual voormorement the #4 dated 4/25/16 revealed the partia			1		l		
1	for Resident	#4 dated 4/25/16 revealed the of a stage two pressure tilder (partial of a stage two presenting as a shallow	1 1		1				
1	identification	of a stage two presents of a shallow as of dermis presenting as a shallow	l		1	,	ł		
1	thickness los	is of define processed had without	1				A sekset Dane 7		
l l	open ulcer w	nay present as an intact or ruptured	1		F8076y 10: 1A0293	ii cougue	ation sheet Page 7		

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING_ C 08/21/2016 a. WING 165273 STREET ADORESS, CITY, STATE, ZIP CODE NAME OF PROMOER OR SUPPLIER 4911 SW 19TH STREET FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB DES MOINES, IA 60315 PROMOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (CS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) F 314 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 eachar (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 hael 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 6/19/16 (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.

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES DENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION C 06/21/2016 P. WANG 165273 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4911 SW 19TH STREET FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB DES MOINES, IA 50315 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION SUMMARY STATEMENT OF DEFICIENCIES OWE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR USC IDENTIFYING INFORMATION) DEFICIENCY) F 314 Continued From page 8 Notification of the family was documented at this 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 cut 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) osteomylitis (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 tissua 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

EPARTN	MENT OF HEALTHAN	ID HUMAN SERVICES MEDICAID SERVICES	 -			(X3) DAT	10. 0938-039 T∉ SURVEY	
ENTER	F DEFICIENCIES		(X2) MUC		COMPLETED			
PLAN OF	CORRECTION	IDENTIFICATION NUMBER!	A. BUILD	NG		C		
			B, WANG			06/21/2016		
		165273	B, WING		ET ADDRESS, CITY, STATE, ZIP CODE			
ANE OF PE	OVIDER OR SUPPLIER	<u>· </u>						
		MA) (AB	4911 SW 19TH STREET DES MOINES, IA 50316					
LEUR HE	IGHTS CENTER FOR W	ELLNESS AND REHAB		L pes	THE PROPERTY OF CORRE	*CDON	(×5)	
(X4) ID PREFIX YAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API OFFICIENCY)	KXILUOS	COMPLETION	
			F	314				
F 314	Continued From page	e 9	'				-	
	located on the right h dark fluid visible und	neel which appears to have er intact skin.						
		Art - Arolin Haallon Record	Ì	l				
	Review of individual	Wound/Skin Healing Record	1	-				
	dated 5/31/16 reveal	ed the would was rered with eschar. The	1				1	
	Unstageable and cov	, measured 3.5 cm by 2 cm.	, i	•	·		1	
	 During observation (of wound care for Resident #4		- 1				
	e/40/46 of 8:40 A	W 259tt V' Redigiolog manos		-				
:	man adhered gum	tles including tape, an						
!	for bonnessess	uza, a wrappeg diessing,						
	a sonor tane me	asine and bisced me					1	
	aupplies on her clipb	poard. The top page on the	}					
	dip board had Staff	A's written notes on it. She 's room, placed the clipboard	f					
	entered the resident	edside table, washed her		- 1			-	
	With supplies on a vi	gloves. The Director of						
	Lea v /m/\M\ was	ia tha mani to odseive ute	1	` }				
	l	PAKEU IUB MONIIS NAN AURI 1704	}	•			·	
	Lead Bayor to cher	AY ING SURSCE OF THE DICE OF		Ì				
	was sale book The V	Noting peg abbeated to no		1				
	shough fissue with 8	datk bluk atea announding						
	A - would had A 9	cant amount of						
	lin our deal	inare was 60000. Didli M	1		1			
	Language the Would	4 MUU IUS babar rahe fo our	1		•		ŀ	
	by 2.2 cm), soakeds	square of gauze with pplied) betading on the	1	ĺ			ŀ	
	Betadine, painteo (a	d the right heel on a pillow to					- 1	
	dry uncovered.	d file right in		1				
	1			1		•		
	Review of Resident	#4's Treatment Administration						
	Decord (TAR) noted	the treatment to the nym	1	1				
	Bankein of sour land	the Motiva with Motiva		}				
	Mannear nat div. di	A DERUT MITU RETERMINA' PURO						
	to average to bit on	re éach day. Sian A	- 1	1				
	i se - to dito cioso fi	he wound with wound inting the heel with betadine	- 1					
	Large envior to no	wing the fieel Will Ociaving	1	- 1				

DEPARTA	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM OMB NO	; 07/15/2016 IAPPROVED . 0938-0391
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AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A BULL	44tj			;
		ļ				06/2	21/2016
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	ROVIDER OR SUPPLIER		4911 SW 10TH STREET				
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) LLCIVIL			10	<u>, </u>	PROMDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU	ION ID-86	(X6) COMPLETION
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F 314	Swinner of war	: h wound cares (from 6/10/16 shed her hands and changed	ļ F	314			
	gloves. She measure Resident's left heel v previously at the hosem by 8 cm with a discovered the wound be dor was noted. She with her gloved finge 4 X 4 squares and p the wound bed. See squares to the wound wound and 4 X 4 squarwapped gauze w dipboard. The Beta outer wrapping and Prafo lift boot to the	which had been debrided pltal. The wound measured 8 soth of 0.3 cm. Hard eschar base and no drainage or foul poked on the wound bed ar and took Betadine soaked laced the soaked squares on buting the soaked 4 X 4 d bed she wrapped the puares with the roll of thich was still located on the dine soaked through the the wound nurse applied the					
	to the left heel was t	o cleanse the would will dry, dry paint with Betadine,					
<u> </u>	1 1 with a dist	ALACSING GRID TOLUCION OF					
	left heel during obse	ent Staff A performed on the ovation was an old order that red on 6/2/16. Staff A again o her gloves appropriately e.					
	at 8:20 AM the resident foot became info care of by staff. The were not elevated of footrest previously.	with Resident #4 on 6/10/16 lent stated the wound on the coted when it was "not taken be resident stated his/her legs if the mattress or her recliner He/she stated after the left covered a blue boot was					
	placed on the left fo	of but not the right took. The					
	heel and his/her bo	itom. The resident stated the			Fig. 10v 1A0033	onlinuation site	et Page 11 of 1

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	AC 418001150			\$18	1 SW 19TH STREET			
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-1 2110 HF	IGHTS CENTER FOR V	VELI.NESS AND REHAB		DE:	THE PLAN OF CORPECTED	V I	¢(5)	
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p 314		er the wounds were from	1	- 1		1		
	Physician tota minum		Ĭ	- 1		1		
	"pressure".		1	- }		1		
	huring an interview	with Resident #4's primary		- 1	,			
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			l	1				
	wound but multiple	factors are inhibiting wound]	1				
	healing.		1	ŀ				
		an annual of the						
	Nurse's Notes doc	umentation revealed the						
			l					
	On Tuesday 5/17/	16 at 2:15 AM - the wound had						
	significantly increa	sed in size, was dark purple in	ł				ł	
	color, and had a d	istinct odor present. The I not state the physician had	1				1	
	documentation did	hongs in the wound.]	
	been notified of th	e change in the wound.					1	
ı	1	jew of Resident #4's chart	1		· · · · ·			
l	1	4 464(PPS 0)) 0/10/10/10/10	}		Ĭ.		1	
	temperature of IV	osis of osteomyelitis. On	1					
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	I Decumentation di	Q VOLIGABOLING bulgaren	ĺ				1	
]	notified of the real	ident's fever.	1		}		1	
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1	During an intervie	w with family members of	}					
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1	14 Jb room 6	TO MOUNTE STATEM HELDER						
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į		blue boot on the left foot was city. The resident's left heef was	1				eet Page 12 o	
1	Latingered correct	tly. The resident's left had was			PSOTIN IO: IA0023	วัตยผู้บักษณ์อน อน	cailede is a	

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I JEACH RESIDENCY	/ MIST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD I	3₹	COMPLETION DATE	
not centered in the op the boot but was pres- the hole. He/she state this however when the visit the boot still was member stated he/she heels floated on pillow member stated the far resident was diagnose (infection of the bone during evaluation in the 5/19/16. The family man thought the facility was changes in the resident notified of the wound of fever on 5/13/16, or the issue on the resident's The resident was observable position in bed was taking place. The were noted on both fer amproved of the boots	en depression at the heal of sing on the padding above ad he/she notified staff of a member returned again to not on correctly. The family a did not see the resident's as when in bad. The mily was shocked when the ad with osteomyelitis at the site of the ulcer) are emergency room on the emergency room of a skin the family interview. Prafo suspension boots and the family members used now. The resident's	F	314				
2. A quarterly MDS as dated 3/6/16 revealed cognition as evidenced points. Resident #2 refrom staff for all activition bed mobility, ambutation tolleting. MDS diagno Non-Alzheimer's disease The MDS noted the respressure, venous, or all the assessment. The MDS Skin and Treaspressure reducing devives provided for the research.	sessment for Resident #2 the resident had an intact I by a BIMS score of 15/15 quired limited assistance es of daily living including on, hygiene cares, and see included se and Diabetes Mellitus. eident did not have any rterial ulcers at the time of preventive items listed in atment Section noted a ce for the chair and bed sident and treatments						
	ROVIDER OR SUPPLIER EIGHTS CENTER FOR WI SUMMARY ST/ (EACH DEFICIENCY REGULATORY OR L Continued From page not centered in the op the boot but was press the hole. He/she state this however when the visit the boot still was member stated the/she heels floated on pillow member stated the far resident was diagnose (infection of the bone during evaluation in th 5/19/16. The family mithought the facility was changes in the resident was obegine position in bed was taking place. The were noted on both fee approved of the boots calves were supported. 2. A quarterly MDS as dated 3/6/16 revealed cognition as evidences calves were supported. 2. A quarterly MDS as dated 3/6/16 revealed cognition as evidences calves were supported. 2. A quarterly MDS as dated 3/6/16 revealed cognition. Resident #2 refrom staff for all activitied mobility, ambutatic tolleting. MDS diagnon Nne MDS moted the respressure reducing devives was provided for the reformation of the pressure reducing devives was provided for the respressure reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives was provided for the respective reducing devives respective reducing devi	F CORRECTION LOST THE FORMAL TO SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST 86 PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ROYDER OR MEDICARE & MEDICAID SERVICES OF DEPICIENCIES (X1) PROVIDERSUSPHEERCULA IDENTIFICATION INMERS: 165273 B. WING ROYDER OR SUPPLIER EIGHTS CENTER FOR WELLINESS AND REHAB SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST 66 PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 raturned 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 ulcar) 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 deterloration, 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 supline 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 16/15 points. Resident #2 required limited assistance from staff for all activities of daily living including bed mobility, ambulation, hygiene cares, and tolleting. 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 praventive items listed in the MDS Skin and Treatment Section noted a pressure reducing device for the chair and bed was provided for the resident an	ROYDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) Continued From page 12 not centered in the open depression at the heak 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 the/she did not see the resident's heels floated on pillows when in bad. The member stated the family was shocked when the resident was diagnosed with asteomyelitis (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 member stated the family hought the facility was updating them on changes in the resident's solutions of a skin issue on the resident's buttocks on 5/19/16. The resident's buttocks on 5/19/16. The resident's buttocks on 5/19/16. The resident's buttocks on 5/19/16. The resident's buttocks on 5/19/16. The resident's buttocks on 5/19/16. The resident's buttocks on 5/19/16. The resident's buttocks on 5/19/16. The resident's acute on both feet and the family interview was taking place. The Prato suspension boots were noted on both feet and the family interview was taking place. The Prato suspension boots were noted on both feet and the family interview acute 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 16/16 points. Resident #2 required limited assistance from staff for all scitivities of daily living including bed mobility, ambutation, hygiene cares, and tolleting. MDS diagnoses included Non-Alzheimer's disease and Diabetes Mellitus. The MDS stin and Treatment Section noted a pressure reducing device for the chair and bed was provided for the resident and treatments	ROYMERORANE & MEDICAND SERVICES OF DEPCHAGES	MENT OF HEALTH AND HUMAN SERVICES 35 FOR MEDICARE & MEDICAD SERVICES OF EXPONENTS DE PROPRIETS AND PROPRETED AND P	

PRINTED: 07/15/2016 FORM APPROVED

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES						RM APPROVELI IO. 0938-0 <u>391</u>
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	of Deficiencies F Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION			PLETEO C
	:	165273	B. WING				01	5/21/2016
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	program or nutritional prevention of skin issues the plan of care noted self-care deficit and rebed mobility and amburement skin issues we and staff was instructed nurse as needed, float tolerated, to provide pland chair cushion. Affinessure ulcer on the 13/26/16 "Heel-lift bootimes-may remove for hand written on the car.	ne MDS reflected the turning or repositioning supplements aimed at less. It Resident #2 had a supplement assist of staff for alation. Interventions to gre initiated on 12/18/15 at to consult the wound at heals off the bed as ressure relieving mattress for identification of a resident 's left heel on the tobe wom at all cares. Will refuse, was re plan. Resident #2 on 3/10/16 6 was "17" indicating the	FS	314				
	record dated 3/28/16 re a stage two pressure u heel. The wound meas with a depth of 0.2 cm purulent drainaga (drai second wound was ide medial aspect of the re 2 cm by 4 cm and was revealed this wound wa During observation of w on 6/15/16 at 11:20 AM Nursing (DON) in the re 3. Licensed Practical N	yound care for Resident #2 with the Director Of oom to observe also, Staff						٧

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

PRINTED: 07/15/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DAYE SURVEY

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	COM	PLETEO
AND PLAN O	CORRECTION	IDENTIFICATION NUMBER.	V Bruto	ING.	·		С
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		165273			STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				1911 SW 19TH STREET		
FLEUR HE	EIGHTS CENTER FOR W	ELLNESS AND REHAD			DES MOINES, IA 50315		
	CHRUADVEY	ATEMENT OF DEFICIENCIES	al al	L	PROMOTION SHOWS PLAN OF CORRECTION		ONS) COMPLETION
(XA) ID FREFIX	IF A OUT DECOMENT!	V MI IRT AF PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BY CROSS-REFERENCED TO THE APPROPRIA	TE	DATE
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E 04.4	G4d Evam page	. 1 <i>4</i>	-	314			
F314	Continued From page	n barrier. Staff C, LPN,					!
	the supplies on a Gos	s sock from the left foot and	1]
	it was noted there was	s no dressing covering the	1				
	wound. The resident	stated at this time he/she					
	had a shower last eve	ning and staff did not					
ľ	re-dress the wound.	The wound had a scant					
}	amount of drainage from	om the wound bed. Staff B					
	and maintained adequ	wound care for the resident	1] [
1	fachujdnes* aud wattratten zoedr	Idle literacii com -	Į.				1
	(Sciiiidaea)		İ				
ĺ	Review of Resident #2	2's TAR noted the treatment	}				1
	to the left heel was to	cleanse the wound with					1
	wound cleanser, apply	Aquacell AG (antimicrobial	1				
	dressing) , and wrep v	vith Kerlix (gauze wrap).] [
1	Nursing staff neglecte wound treatment for the	d to provide appropriate			'		
	wound treatment for a resident's shower on 6	RHAMA					
	169maura allowal ou c	W 1-17 1 VI		į			
1					·		
	3. Resident #3 had &	quarterly Minimum Data	1	į]
	Set (MDS) assessmer	t, dated 5/16/16, which					
ŀ	revealed the resident l	had an intact cognition as	ļ.				
	evidence() by a BIMS:	score of 15/15 points. The sident as independent with			·		
	MDS 8889sseu die lee	ing except toileting. MDS	}				
ļ	diagnoses included he	art failure and obesity. The		-			
	MDS noted the resider	nt did not have any					ľ
- 1	MARRIED VARIOUS OF 8	rterial ulcers at the fime of	1				ŀ
	the assessment. The A	NDS identified the resident		- {		ľ	
,	at risk of developing pa	ressure ulcers. The		ı			
ŀ	preventive items listed	ill (lie MDS Skill glio Ill (lie MDS Skill glio]	
	Treatment Section not	ed a pressure reducing d bed was provided for the					1
}	oeyice tot the chair an	s Included application of					
1	ointments/medications	other than to feet.	}				1
1				1		1	-
}	The care plan noted th	e method of embulation	1		•		
	and transfer was chang	ged to staff assist with the	1		The second of continues	Kon sheef	Page 15 of 19

	MENT OF HEALTH AN				<u></u>	FO	ED: 07/16/2016 RM APPROVED IO. 0938-0391
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AND PLAN OF	- COMMECTION	(524)(1747)	A BUILD				С
		_	o marc			0	3/21/2016
		185273	B. WING		STREET ADDRESS, COY, STATE, ZIP CODE		JIZ 1720 1 <u>0</u>
NAME OF P	ROYDER OR SUPPLIER		•				
					4011 SW 19TH STREET		
FLEUR HI	EIGHTS CENTER FOR W	EL'TUESE AND KEHAB		Ì	des moines, IA 50315		
	CIRIMADV QYA	TEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION		(XS) COMPLETION
(X4) ID PREFIX	#SACH DESICIENCY	/ MUST BE PRECEDED BY FULL	PREF		(FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	XE	DATE
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F 314	Continued From page	15	F:	314	<i>i</i> }		1
		nd lift stand on 5/19/16.			İ		
	After identification of U	instageable ulcer to the left					1
	heel on 6/5/16 "Heel-	lift boots, Arginine (wound			}		
	theating supplement) a	nd Multi-vitamin to start					
	"was hand written on t	he care plan.					1
	Was Halle Willell on	110 uni v p			1		f
	The Braden scores for	Resident #2 on 5/19/16,			1		
	arior to big/her decline	, was "20" indicating the					
	resident use not at rist	k for developing pressure	1				}
	ulcers.	(10) 4-1-1-F-1-Q -	1				
1	uiceia.		-				
	Deview of Resident #3	's Wound/Skin Healing					1
Ĭ	report dated 6/5/16 (6)	vesled the Identification of					
ł	an unctaneable areast	re ulcer located on the left			<u> </u>		
	heal. The wound man	sured 4.8 cm by 8.3 cm					} [
	with an open area of 4.	.8 cm by 4,5 cm A	ł]
	moderate amount of Se	erosanquinous drainage	İ				
	was documented. The	record reflected Prafo	1				1 1
ľ	boots were ordered for	the resident.	}				_
ļ	2044-11-11-11						! [
	Observation on 6/10/16	at 8:00 AM revealed	· ·	ı			! !
	Resident #3 seated in a	a wheelchair in his/her		 			<u> </u> 1.
j	room. The resident's fe	et were uncovered. The					[
	left foot had a dressing	over the heel and the	1	- [
	dressed heel was restir	ng on the floor without a]			
	banier.			j			1
1			1	- 1			
1	During observation 6/10	0/16 at 9 AM Staff A, RN,		- }			
	nlaced dressing supplie	es (unwrapped roll of					1
1.	neuze. 4 X 4 dauze squ	lares sprayed with Wound	1	ı		1	İ
4.7	cleanser, and tape mea	isure) on the clipboard and		- }			
- I.	entered Resident #3's r	oom to provide wound]
f,	care. Resident#3 was	seated in a wheelchair	1	- 1			·
١,	with his feet on the floor	r. Staff A noted the		-			· · · }
- In	resident's feet did not h	ave blue boots on and	Į			į	•
١,	stated the resident was	to wear the heel-lift blue		1	•		
11	poots at all times. Staff	A washed her hands and					ľ
- 17	noved. She took the of	d dressing off the					1
	esident's heel and char	nged her gloves. The	İ	I.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES								
r —		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE A, BUILDING	OX3) DATE SURVEY COMPLETED C				
		165273	B. WING		08/21/2016			
	PROVIDER OR SUPFLIER IEIGHTS CENTER FOR WI	ELLNESS AND REHAB	49	TREET ADDRESS, CITY, STATE, 2IP CODE 111 SW 19TH STREET ES MOINES, IA 50315				
				PROVIDER'S PLAN OF CORRECT!	ON (x6)			
(X4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROX DEFICIENCY)	U BE CONFIERON			
F 314	Continued From page	16 rve the procedure, held the	F 314					
	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							
	cleanser and took a Te	ed the wound with wound lifa (non-stick) dressing out placed the clean dressing						
	onto the dressing. She dressing and heel and	wrapped the foot with the						
	to the resident's wound the physician to ask if t							
	continued since the wo completely covered will							
	to the left heel was to o	s TAR noted the treatment deanse the wound with /, apply Santyl, cover with						
	dry dressing, and wrap as needed. The TAR n	with gauze twice daily and leted the resident was to The TAR did not instruct						
],	etaff to place heel lift bo noted the care plan.							
	Review of a Physician P 3/10/16 revealed the phy vound as a left heel ulca	ysician diagnosed the er with cellulitis. The						
ļi	esident was placed on l ntramuscular injection d	aily for seven days.						
a	it 9:15 AM the resident a inderstanding that the b	oots were to be on all the			y 1 1			
n g	me. Hersne stated stati ight. This morning whe et up staff did not put so is/her feet and he negla							

PRINTEO: 07/16/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAIO SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING_ C B. WANG 165273 08/21/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4911 SW 19TH STREET FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB DES MOINES, IA 50315 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY F 314 | Continued From page 17 F 314 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 ambutation have interventions placed to float haels by placing pillows under their calves when in bed and pressure relieving mattrasses 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 weakly 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

	TMENT OF HEALTH AN RS FOR ME <u>DICARE &</u>					FORM): 07/16/20 1 APPROVE): 0938-039	
STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF GORRECTION (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. VANG			(X3) DATE SURVEY COMPLETED C 06/21/2016			
165273								
NAME OF E	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	STATE, ZIP CODE			
FLEUR HEIGHTS CENTER FOR WELLNESS AND REHAB				4911 SW 19TH STREET DES MOINES, IA 503		A		
(X4) IO PREFIX BAT	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF GORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			OVAE CONSTELION (X2)	
i i	agreed Staff A, did not control techniques whi Resident #4 and Reside should have had a dreater his/her shower. Sto the position of wound additional training for water and training for Staff A through the DON stated facility for one month an education to provide for preventative pressure us consistent heel floating for residents at risk. The residents should be the preventative skin interventions should be Review of the facility Sk Treatment Policy, review	follow proper infection le providing wound cares to lent #3 and resident #2 ssing on his/her wound She stated Staff A was new d nurse and had requested round care techniques. ould arrange additional ligh the Hospital Wound if she has been at the and realizes she has r staff concerning alcer interventions such as and application of boots be DON agreed that all roughly assessed for entions and appropriate implemented. in Care and Early of date of 1/2013, noted 16 points on the Braden uld have the following	F	314				