Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC#6410				**Date: Jan. 13, 2017**
Fountain West Health Center		**Survey Dates: Nov 5,17 22,23,28-30 & Dec. 5-7,20 2016 & Jan. 11-24**		
1501 Office Park Road				
West Des Moines, IA 50265	**JKM**			

		Class	Fine Amount	Correction date
56.6(1)	**481—56.6(135C) Treble and double fines.** **56.6(1)** *Treble fines for repeated violations.* The director of the department of inspections and appeals shall treble the penalties specified in rule 481—56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor.	**I**	**$30,000.00** **Treble Fine ($10,000 x 3)** **Held in Suspension**	**On Receipt**
58.28(3)e	**481—58.28(135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) **58.28(3)** *Resident safety.* *e.* Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)			
58.19(1)g	**481—58.19(135C) Required nursing services for residents.** The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: **58.19(1)** *Activities of daily living.* *g.* Ambulation with equipment if applicable, or transferring, or positioning; (I, II, III)			

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	DESCRIPTION: Based on observation, record review and staff interview, the facility failed to provide adequate nursing supervision to prevent accidents 9 of 13 residents reviewed. Physical Therapy (PT) identified Resident #1, #2, #9, and #43 required assistance with transfers and ambulation (walking). The residents continued to self-transfer and not always use the call light. The facility did not consistently implement interventions to address the residents' risk of falls resulting in multiple falls and injuries, including hip fractures. Resident #1 died as the result of complications of hip fracture. Resident #11 fell with head injury when he/she attempted to self-transfer. No one heard the resident's alarm. Resident #3 was allowed to self-transfer even though a PT treatment note dated 8/11/16 revealed PT and nursing both collaborated on Resident #3 requiring one person assist with transfers. After falls, the facility did not implement new interventions. Resident #45's care plan directed the resident required assistance with transfers and ambulation. The facility implemented interventions after most falls, but two (2) of the interventions relied on the resident's memory although he/she experienced persistent cognitive deficits. Resident #7 sustained repeated skin tears to the left elbow from bumping into the wall or doorframe when staff used the EZ stand. Resident #22 was placed in an EZ stand and facility staff then left him/her alone for an extended period of time. The facility identified a census of ninety-three (93) residents. Findings include: 1. A Minimum Data Set (MDS) assessment tool dated 9/17/16 revealed Resident #2 had a diagnosis of			

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	dementia and a brief interview for mental status (BIMS) score of "5" (severe cognitive impairment). The resident displayed the following indicator of delirium that fluctuated through the day: inattention, and had no behavior symptoms identified. The resident required limited staff assistance with bed mobility, transfers and ambulation and extensive staff assistance with toilet use, dressing and personal hygiene. A "balance during transitions and walking" test identified the resident as not steady and only able to stabilize with staff assistance. The resident used a walker and wheelchair for mobility and was occasionally incontinent of bladder. Falls: An incident report (IR) dated 8/9/16 at 6:40 a.m. revealed the resident fell in his/her room. The resident had walked with a glass of water and spilled the water on the floor. He/she then slipped in it, fell on his/her bottom and hit his/her head on the bed frame. The resident complained of head and back pain following the incident. The IR listed the intervention following the incident: encourage reminders and encourage resident not to walk with water in room. Have staff assist with carrying water as appropriate. Following the incident, a transfer form dated 8/9/16 identified the resident transported to the emergency room (ER) for evaluation. Nursing progress notes dated 8/9/16 at 12:51 p.m. revealed the facility received a phone call from the hospital ER stating the resident would return to the facility. Labs, spine x-rays and head CT (computerized tomography) were all within normal limits. ER personnel stated they gave the resident 50 mcg (micrograms) of Fentanyl (narcotic) with no further back pain noted. The			

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	resident returned to the facility at 1:40 p.m. The resident complained of continued back pain when he/she moved certain ways and continued to have a slight headache. An x-ray report dated 8/14/16 revealed osteoporosis and an age indeterminate compression fracture of T11. A CT of the abdomen and pelvis dated 8/18/16 revealed a T10 compression fracture with near complete vertebral body height loss. A physical therapy (PT) outpatient discharge form identified the PT end date as 8/24/16. The form identified the resident ambulated with contact guard assistance (CGA) of one staff and a front wheel walker, and transferred with limited to extensive assistance of one staff. Nursing progress notes dated 8/29/16 at 3:07 a.m. revealed the resident apparently walked to their roommate's recliner. The resident did not use the call light. The entry identified the resident required "assist of one assist with walker." Nursing progress notes dated 9/3/16 at 6:05 p.m. revealed there were times the resident ambulated alone and did not use the call light. Staff educated the resident to use the call light to request assistance. An MDS dated 9/3/16 identified the resident with a BIMS score of "6" (severe cognitive impairment). Nursing progress notes dated 9/4/16 at 1:27 p.m. revealed staff observed the resident ambulating in his/her room. Staff repeated cues and reeducation regarding the need to call for assistance and safety awareness.			

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	Nursing progress notes dated 9/14/16 at 5:05 p.m. revealed the resident wanted to go to the bank and walked down the hall by themselves without assistance or a walker. Staff reeducated the resident and assisted the resident back to his/her room. Staff also reminded the resident to use the call light and wait for help. Nursing progress notes dated 9/15/16 at 6:23 a.m. revealed the resident was up without the walker. Staff then assisted the resident to the toilet. A restorative program form dated 9/15/16 directed staff should ambulate the resident with front wheeled walker and CGA of one staff. A physician encounter note dated 9/20/16 at 2:08 p.m. identified the resident experienced debility and required increased assistance with transfers and ambulation. An IR dated 9/28/16 at 5:40 a.m. revealed staff found the resident sitting on the floor in front of the recliner in his/her room. The resident denied pain and did not hit his/her head. The resident sustained a small, pinpoint open area to the lower left extremity. The IR identified the resident's transfer/ambulation needs as "up with assistance of one with front wheeled walker and gait belt." The IR did not identify an intervention placed following the incident. Nursing progress notes dated 9/29/16 at 2:40 p.m. revealed the resident up and wandering in the hallway a couple times on that shift. Staff talked to the resident about using the call button and need for the walker and staff assistance to prevent falls. The resident voiced understanding but seemed forgetful. A care plan intervention dated 9/30/16 revealed the resident required limited to extensive assistance of one			

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	staff for transfers and toilet use. The resident required contact guard assistance of one staff with a front wheeled walker. (According to PT 8/24/16 the resident required one staff assistance and walker) The resident was on a prompted toileting plan on 9/30/16. Nursing progress notes dated 9/30/16 at 10:27 a.m. documented the resident required CGA assistance with ambulation and transfers. Nursing progress notes dated 10/3/16 at 4:53 p.m. identified the resident standing up by themselves in their room. An IR dated 10/14/16 at 3:15 a.m. revealed staff found the resident sitting on the floor in his/her room with the resident's back against the foot of the bed. The resident did not know how he/she ended up on the floor. The IR identified the intervention following the incident as "assure needs are met before leaving room." The care plan intervention box identified this intervention was in place since 4/19/16. An IR dated 10/14/16 at 8:30 p.m. revealed staff found the resident seated on the floor. The resident fell trying to get clothes out of the closet. The resident hit his/her head on the bathroom door. The IR did not identify an intervention following the incident. An IR dated 10/16/16 at 5:15 a.m. revealed the resident stated he/she came out of the bathroom and fell. Staff found the resident sitting on his/her bottom on the floor in his/her room. The resident said he/she hit their head on the edge of the bed. Staff applied an ice pack to the head. The resident received a hematoma to the right forehead and abrasion to the buttock. The IR did not identify an intervention following the incident.			

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	Nursing progress notes dated 10/16/16 at 9:16 a.m. revealed the resident transferred to the ER for evaluation. Nursing progress notes dated 10/18/16 at 1:36 p.m. revealed the resident had a 1 centimeter (cm) by 4 cm scrape to the right upper buttock with a scant amount of blood noted, a 2 cm by 0.1 cm scrape on lower buttock with a scant amount of blood noted, and a 5.5 cm by 1 cm scabbed area on the right hip. Staff documented all above areas were due to the resident's previous fall. A physician encounter form dated 10/17/16 at 4:51 p.m. revealed the resident transferred to the ER on 10/16/16 after a fall. The resident had bruising above and below bilateral (both) eyes as well as to the right forehead. The ER evaluated the resident with laboratory tests, left hand X-rays, and a CT of head. The left hand X-ray showed mild osteopenia and mild degenerative arthritis. The bruising was described as follows: Examination of the head and face revealed hematoma around bilateral eyes and right forehead and tenderness over the right frontal area. The right eyelid showed swelling of the upper eyelid and extensive bruising around bilateral eyes. The resident fell 4 times in the past week. The resident used a walker with assistance and transferred with assistance. The resident used a wheelchair for longer distances. The resident's motor strength revealed the resident displayed weakness in both upper and lower extremities. A CT of the abdomen/pelvis on 8/18/16 revealed a T10 compression fracture. A Tinetti assessment tool identified the resident with a combined balance and gait score of 11/28. A score of less than 21 identified the resident at high risk for falls.			

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	An IR dated 11/1/16 at 8 a.m. revealed staff found the resident sitting in the hallway on his/her bottom with the left leg flexed outward with his/her back up against the wheelchair wheel. The foot pedals were in the down position. The resident yelled with range of motion (ROM) and told staff to take him/her to the hospital. A statement dated 11/1/16 and written by the charge nurse revealed the resident was last seen at 7:30 a.m. At that time, the resident tried to ambulate by themselves. The nurse went to pass medications and left the resident with a CNA (certified nurse aide). At 8 a.m., the charge nurse heard someone fall from the end of the hallway. When she investigated the noise, she observed the resident on the floor with staff beside the resident. A transfer form dated 11/1/16 identified the resident transferred to the hospital following the incident. The transfer form revealed staff found the resident sitting in the hallway on the floor with his/her back against the wheelchair wheel and wheelchair pedals in the down position. The form identified that there were no witnesses to the incident. Nursing progress notes dated 11/1/16 at 1:24 p.m. revealed ER phoned and reported Resident #5 had sustained a left femur fracture and would undergo surgery to repair the fracture. A PT discharge summary revealed the resident did not progress significantly with 3 PT sessions prior to hospitalization on 11/1/16. The resident continued to exhibit cognitive deficits with poor safety awareness and insight into his/her deficits. The resident continued to self-transfer and be noncompliant with waiting for CNA assistance.			

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	Nursing progress notes dated 11/9/16 at 12:23 a.m. revealed the resident returned to the facility from the hospital at 4:30 p.m. on 11/8/16. The resident had some bruises on arms from IV's at the hospital and 25 staples in the left hip incision. The resident utilized the EZ stand and 2 staff for transfers. Nursing progress notes dated 11/10/16 at 4:20 a.m. revealed the resident showed inadequate awareness of self-limitations and staff anticipated most to all of the resident's needs. A physician visit encounter form dated 11/10/16 identified the resident sustained a left femoral neck fracture secondary to a mechanical fall. The resident attempted to stand up from the wheelchair and fell. The resident readmitted to the facility following ORIF (open reduction and internal fixation) repair of the left femoral neck fracture. A hospital trauma daily progress note dated 11/8/16 identified the resident sustained a spiral oblique fracture of the proximal left femoral diaphysis with associated 9 cm shortening. The report also identified the resident exhibited bilateral eye bruising. Nursing progress notes dated 11/20/16 at 4:20 a.m. revealed the resident sat up to go to the bathroom and slid off the bed to the floor. Staff found the resident on the floor at the bedside. The resident did not use the call light and the resident was barefoot. The resident's brief was wet. The resident did not sustain injury. The intervention on care plan dated 11/21/16 after the incident directed staff to take the resident to the bathroom on second rounds. Nursing progress notes dated 11/26/16 at 1:01 a.m. revealed staff checked the resident every 30 minutes and found the resident sitting in his/her recliner chair. The			

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	resident did not use the call light and then self-transferred to the recliner. Staff educated the resident to use the call light for assistance. Nursing progress notes dated 11/30/16 at 9:32 p.m. identified staff saw the resident ambulating in his/her room without assistance. Staff encouraged the resident to call for assistance when he/she wanted to stand up and walk around. The care plan did not contain any new interventions following the 11/26/16 and 11/30/16 documentation of self-transfers/ambulation. Nursing notes dated 12/1/16 at 3:07 a.m. revealed staff continued to check the resident frequently as the resident was noncompliant with call light use. Staff documented reeducation continued without effectiveness due to cognitive decline. Care Plan: The care plan identified an intervention dated 9/28/16 that directed staff to place the recliner in a safe sitting position when the resident sat in the recliner. The point click care (PCC) care plan box identified staff created the intervention on 11/2/16. The care plan identified an intervention dated 10/17/16 that directed staff to observe resident for signs and symptoms of restlessness during the night time hours. Offer toilet, snack, or relaxing activities if increased restlessness noted. The PCC care plan box revealed staff created the intervention on 11/2/16. The care plan identified an intervention dated 10/17/16 that directed staff to place a call light reminder sign by			

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	the resident's bed. The PCC care plan box revealed staff created the intervention on 11/2/16. An intervention on the care plan "follow facility fall protocol" created on 4/19/16, identified the intervention “follow facility protocol" had been in place since that date. Review of the facility fall protocol revealed staff would complete a fall assessment on the first day of admission. If the fall assessment identified the resident as at risk for falls, the team leader/case manager would instruct the staff to monitor the resident frequently, answer the call light promptly and add any other safety measures to help protect the resident. Staff Interviews: On 11/17/16 at 2:34 p.m. Staff E, LPN unit manager stated she worked when the resident fell on 11/1/16. Staff heard the resident yelling. When Staff E saw the resident, he/she was sitting on the floor. When Staff E asked the resident if he/she could rotate his/her leg, the resident yelled out in pain. The resident complained of hip pain. Staff E stated she thought the resident did get up without help. On 11/17/16 at 2 p.m. Staff F CNA stated she worked when the resident fell on 11/1/16. She came up the 100 hall and heard someone yell "help me". After she finished what she was doing, she went down the 300 hall and saw the resident on the floor. She stated she didn't know where the 300 hall staff were. She started the resident was about 3 feet from the resident room door. The resident complained of knee pain. Staff F called for help and the DON (director of nursing) and ADON (assistant director of nursing) arrived. When asked what was being done for the resident to prevent falls, Staff F stated she			

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	couldn't think of anything as the facility was going "alarm free." Staff F reported Resident #5 was care planned to get up with staff assistance, was not to be up by him/herself and did not wait for help; reeducation did not help, and staff offered resident things to occupy him/her. Staff F also reported the resident did not use the call light. In Staff F's written statement dated 11/1/16, she wrote she last saw the resident at 6:30 a.m. standing in the doorway. At that time, Staff F redirected the resident to the recliner and offered the resident the toilet and a drink. The resident refused both. On 11/17/16 at 3:35 p.m., Staff G CNA stated prior to the 11/1/16 fracture, the resident got up all the time. Staff G found the resident found Resident #5 transferring or ambulating without assistance in the hallway and in the dining room. On 11/28/16 at 2:58 p.m. Staff H CNA stated the resident was known to get up without asking for assistance On 12/6/16 at 8:10 a.m. the DON stated the created date in the point click care plan box was the date the intervention was created. She stated at the end of August a new unit manager (UM) took over and there was miscommunication regarding inputting the new interventions on the care plan. On 12/5/16 at 10:41 a.m. Staff A, CNA (certified nurse aide) stated the resident tried to stand up constantly - 4 to 5 times a shift. The resident also did not like to use the call light and tried walk to his/her closet or the bathroom as the resident wanted to use the bathroom frequently.			

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	On 11/28/16 at 2:40 p.m. Staff B, LPN (licensed practical nurse) stated the resident was known to get up and not use the call light. Sometimes staff found the resident in the midst of standing up when Staff B walked by the room. On 11/17/16 at 3:12 p.m. Staff D, LPN stated the resident was known to get up without waiting or using the call light once in a while. On 11/28/16 at 2:58 p.m. Staff H, CNA stated the resident was known to get up without asking for help. Staff H would ask the resident to sit for a second and 2 minutes later the resident would stand up. When Staff H came back, it would startle the resident. Observation: On 11/22/16 at 11:35 a.m. observation showed Staff I CNA transferred the resident and placed the resident in the wheelchair without a gait belt. Staff I confirmed he did not use a gait belt, but stated he did use the walker for the transfer. Observation showed the walker by the wall approximately 8 feet from Staff I and the resident. The care plan in place 11/22/16 contained an intervention dated 11/21/16 that directed staff to stand pivot transfer the resident with one to two staff, gait belt and front wheeled walker. 2. An MDS dated 9/15/16 documented Resident #1 had diagnoses of dementia and stroke with a BIMS score of "5" (severe cognitive impairment). The MDS also documented the resident did not ambulate and required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, and personal hygiene. The MDS revealed the resident showed functional range			

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	of motion (ROM) limitations of the upper and lower extremities, used a wheelchair for mobility and experienced two or more falls without injury since the previous assessment. A care plan with a completion date of 10/5/16 identified the resident as at risk for falls related to balance problems, functional ROM problems, osteoarthritis, osteoporosis, severely impaired cognition, incontinence and medication use. The care plan directed staff to encourage the resident to self-propel his/her wheelchair and assist as needed (extensive assist of one staff for locomotion in wheelchair). The care plan also directed staff to assist the resident with transfers to desired destination (bed, recliner, toilet, etc.) shortly after meals. The resident used a sensor alarm in the wheelchair. An IR dated 10/17/16 at 7:20 p.m. revealed staff found the resident lying on his/her right side in the central hallway with a large bump on the forehead and a bloody nose. The resident reported back pain. The alarm sounded when the resident fell. The "investigation" portion of the incident report was blank. On 11/23/16 at 1:55 p.m., Staff K LPN stated the resident was in the central hallway and fell out of the wheelchair. She stated there was a family visiting another resident in the central hall and they alerted staff to the resident's fall. No staff heard the resident's wheelchair alarm. Staff found the resident first on the ground. Staff K called the ambulance and the resident transferred to ER for evaluation. Staff K stated after the incident the resident had black eyes. Nursing progress notes dated 10/18/16 at 12:08 a.m. revealed the hospital called and informed the facility the resident had a UTI (urinary tract infection) and the resident would return with an order for Keflex (antibiotic)			

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	to treat the UTI. The head CT and chest X-ray were unremarkable. Nursing progress notes dated 11/27/16 at 8:34 p.m. revealed staff found the resident sitting on the floor in front of the wheelchair. The resident attempted to self-transfer to bed. The notes did not identify if the alarm activated. The resident did not sustain injury. Review of the current care plan revealed no new intervention(s) added following the incident. The incident report dated 11/27/16 at 8:30 p.m. revealed the alarm failed to sound when the resident attempted to self-transfer. The incident report also revealed staff added no new intervention(s) following the incident. Observation on 11/23/16 at 1:10 p.m. revealed Staff L CNA transferred the resident to the toilet via the EZ stand. The alarm sounded when Staff L assisted the resident to stand. Staff L stated she took care of the resident on 10/17/16, but the resident fell after he/she left. The next day the resident had 2 black eyes. 3. An MDS dated 7/21/16 assessed Resident #3 with a BIMS score of 8 (moderate cognitive impairment). The resident required extensive staff assistance with bed mobility, dressing, toilet use, personal hygiene and bathing. The resident required limited staff assistance with bathing. A "balance during transitions and walking" test identified the resident as not steady but able to stabilize with staff assistance. The resident used a walker and wheelchair for mobility. The MDS identified the resident received daily anticoagulant medication. A physical therapy (PT) treatment note dated 8/11/16 revealed the PT and nursing both collaborated on the resident being one person assist. The resident			

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	discharged from PT on that date. The resident remained at risk for falls and nursing educated and posted signs in room to wait for staff assistance prior to attempting to transfer. Care plans with completion dates of 7/20/16 and 10/20/16 identified the resident as independent to limited staff assistance of one with transfers. Falls: An IR dated 9/14/16 at 11:30 a.m. revealed staff found the resident seated on his/her bottom with legs stretched out in front of him/her and the resident's back on the wall by the toilet. The resident stated he/she went down easy and fell getting off the toilet. The resident did not sustain injury. The IR identified the intervention after the incident as "assure needs are met before leaving room". The 7/20/16 care plan already had the following intervention in place: anticipate and meet the resident's needs as appropriate" dated 3/4/15. An IR dated 9/24/16 at 12:45 a.m. revealed staff found the resident seated on the floor by the bed. The resident did not sustain injury. The IR did not identify an intervention following the incident. An IR dated 9/24/16 at 2:45 p.m. revealed the resident slipped forward out of the wheelchair when a CNA pushed the resident without foot pedals. The resident hit his/her right temple on the wall and received a small, tender abrasion. Staff assisted the resident back in the wheelchair. The intervention following the incident was to have foot pedals available on the back of the wheelchair and educate employees on proper procedure. The care plan did not contain the intervention. An IR dated 10/9/16 at 7:10 p.m. revealed staff found the resident lying on his/her side on the floor. The resident received a skin tear from the incident. The intervention			

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	following the incident was to educate the resident to use the call light. According to the 7/20/16 care plan the care plan already contained an intervention that directed staff to ensure the resident's call light was in reach and encourage the resident to use it. Staff needed to answer the call light promptly. An IR dated 10/10/16 at 7:10 p.m. revealed staff found the resident on the floor seated on his/her bottom in the resident room. The resident stated he/she attempted to transfer from the wheelchair to the bed and fell. The resident hit his/her head on the night stand resulting in a bump measuring 0.7 cm. by 0.7 cm. on the back of the head. The IR did not have an intervention listed following the incident. An IR dated 10/20/16 at 1:20 a.m. revealed staff heard the resident yell, "help me". Staff found the resident on the floor in his/her room between the wheelchair and bed. The resident's head was up and the resident was in a sitting position in his/her room. Staff did not observe injury. The intervention following the incident was "call light reminder sign paced on bedside table and assure bedside table is next to resident when in bed". The resident already had a reminder sign in place on 8/11/16 to wait for staff assistance. The care plan completed on 10/20/16 continued to contain the intervention that identified the resident as independent to limited staff assistance of one with transfers. An IR dated 11/19/16 at 7:45 p.m. revealed a fall in the resident room. The resident tried to get to bed without shoes on and fell to the floor. The resident did not sustain injury. The intervention following the incident was to assure the resident wore shoes.			

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	An IR dated 11/20/16 at 6:30 p.m. identified a fall in the resident room. Staff found the resident on the floor lying on his/her back between the bed and window. The wheelchair was at the foot of the bed. Staff did not observe injury. There was no intervention listed following the incident. An IR dated 11/22/16 at 5:30 a.m. revealed a fall in the resident room. Staff found the resident on the floor next to the bathroom. The resident could not explain what occurred. The IR identified the resident had previously been anxious. The resident sustained a bump to the forehead that measured 2 cm. by 2 cm. The intervention following the incident was to answer the resident promptly when he/she called. (Already in place) and a PT/Occupational therapy (OT) screen. Nursing progress notes dated 11/22/16 at 5:31 p.m. revealed staff observed a skin tear on the right upper arm with purple discoloration surrounding it. The skin tear measured 0.5 cm. by 6 cm. by 0.1 cm. Staff closed the wound with 6 steri strips. The resident did not know how the injury occurred. There was no incident report for the injury. An IR dated 11/22/16 at 7:30 p.m. revealed a fall in the resident room. Staff attempted to transfer the resident from his/her wheelchair into bed. The resident's knees buckled and the resident went to the ground. The resident did not have shoes on. The resident did not sustain injury. A hospital report dated 11/23/16 revealed the resident fell 3 times in the past 3 days. The resident sustained arm lacerations to both arms and a left sided forehead hematoma. The report identified a left wrist skin tear and right bicep skin laceration.			

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	On 11/23/16 at 9:28 a.m. Staff M LPN unit manager confirmed the resident toileted self. Observation: Observation showed on 11/17/16 at 10:20 a.m. the resident in the bathroom. At that time, Staff L CNA stated the resident would take themselves to the bathroom and when he/she wanted off the toilet, the resident would pull the call light. On the same date at 10:35 a.m., the resident transferred themselves to bed. Staff L stated the resident was in the process of transferring when he/she entered the room. The resident did not use the call light. On the same date at 10:55 a.m., the resident transferred themselves from bed to wheelchair. On 11/28/16 at 11:37 a.m., the resident wheeled themselves using their feet in the wheelchair. Observation showed a large bruised area around the left eye. When asked what happened the resident stated "it's been like that a long time". The record lacked documentation of a left black eye. The DON supplied documentation on a sheet of legal pad paper, a list of interventions implemented following falls: 9/14/16 Staff to offer restroom prior to meals. The care plan identified the resident was already on a prompted toileting plan which identified prompted toilet before meals in place since 3/4/15. 9/25/16 assure resident with appropriate position in wheelchair for safety. (This intervention was not on the resident's care plan and the PCC care plan box identified this intervention was created on 11/17/16)			

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	9/26/16 During sleeping hours observe resident for restlessness and if he/she is awake offer drinks, snacks and toilet. The PCC care plan box identified this intervention was created on 11/17/16 (The resident already had an intervention on the care plan to observe for restlessness and provide calming activities dated 6/29/16) 10/10/16 Provide patient education related to safe sitting/standing when appropriate. (The MDS identified the resident with a BIMS of 8, moderate cognitive impairment) 10/20/16 Call light reminder sign on bedside table. (PT notes identified the resident already had a sign in place 8/11/16 to wait for help) 11/20/16 Staff to assure the resident's wheelchair placed next to bed. The PCC care plan box identified this intervention was created on 11/22/16. 11/22/16 Assure call light answered promptly. According to care plan review, this intervention was already in place since 3/4/15. 11/22/16 Offer snacks and drinks as needed through the day. The PCC care plan box identified this intervention was created on 11/28/16. 4. An MDS dated 10/14/16 assessed Resident #1 with a BIMS score of "9" (moderate cognitive impairment). The			

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	resident had no behavior symptoms identified. The resident required extensive staff assistance with bed mobility, dressing, toileting and bathing. The resident required limited assistance of staff with ambulation and personal hygiene. A "balance during transitions and walking" test identified the resident as not steady but able to stabilize without staff assistance in all areas of testing. The resident used a walker and wheelchair for mobility. The MDS identified the resident admitted to the facility 10/7/16. The resident was occasionally incontinent of bowel and bladder. The resident had diagnoses that included: dependence on renal dialysis and altered mental status. The resident had one fall without injury since admission. A Tinetti assessment tool identified the resident with a fall risk score of 8/28. A score less than 21/28 revealed a high fall risk. The initial care plan dated 10/7/16 identified the resident as at risk for falls and required assistance of 1 staff with bed mobility, transfers and ambulation. A care plan with completion dated of 10/12/16 revealed the resident required assistance of one staff with transfers and assistance with toileting. The care plan identified the resident with a risk for falls. The interventions to assist with the prevention of falls and all dated 10/18/16 included: anticipate and meet the resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, educate resident/family/caregivers about safety reminders and what to do if fall occurs, follow facility fall protocol and PT evaluate and treat as ordered or PRN (as needed) . An addendum dated 10/24/16 revealed a directive for frequent visual checks. The care plan also identified the			

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	resident experienced bladder incontinence and directed staff to encourage fluids to promote prompted voiding responses. Facility fall protocol dated 11/2013 directed staff to complete a fall assessment on the first day of admission. If the fall assessment identified the resident as at risk for falls, the team leader/case manager would instruct the staff to monitor the resident frequently, answer the call light promptly and any other safety measures to help protect the resident. On 12/6/16 at 1:50 p.m. Staff E LPN unit manager identified frequent checks as every 2 hour checks at night. On 12/6/16 at 1:52 p.m., Staff N RN (registered nurse) unit manager stated she did not have any residents who required frequent checks on her hall. She stated when she did, the checks were every 2 hours at night. On 12/6/16 at 1:57 p.m. Staff M LPN unit manager stated frequent checks were looking in when going by the room and every 2 hours or as "often as you can". On 12/6/16 at 2 p.m. the DON stated she didn't know what frequent checks meant. She stated she guessed it depended on the person. A hospital discharge summary dated 10/7/16 revealed the resident had a history of frequent falls. When the resident arrived to ER they noted a left frontal scalp hematoma and facial ecchymosis. The discharge summary revealed this injury occurred when the resident's family attempted to lift the resident and bumped the resident's head. A PT flowsheet note included with the resident's hospital discharge information and dated 10/5/16 revealed safety concerns. The resident was at risk for falls and required 2 staff for			

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	bed mobility and transfers/mobility. A MD/nursing communication form dated 10/10/16 at 8:36 p.m. revealed staff found the resident on the floor between the bed and night stand. The resident stated he/she tried to get to bed and lost balance. The resident sustained no visible injuries. The record failed to identify a new intervention after the incident. An incident report dated 10/10/16 at 8 p.m. revealed the resident fell attempting to self-transfer to bed. The intervention listed on the IR following the incident was to educate the resident to use the call light. A resident encounter form dated 10/12/16 revealed the resident admitted to the facility following hospitalization for weakness, frequent falls and encephalopathy. The resident had ecchymosis to the forehead and scalp. A MD/nursing communication form dated 10/23/16 revealed the resident attempted to self-transfer at 5 p.m. on that date. The resident fell resulting in a moderate size hematoma with surrounding bruising. The form did not identify the location of the resident's injury. Staff M LPN unit manager documented the resident admitted to the hospital 10/25/16 and according to the nurses note on 10/23/16 the injury was on the "mid frontal area". An IR dated 10/23/16 at 5 p.m. revealed staff observed the resident on the floor lying on their right side with their head facing south and feet to the north. The call light was not activated. The resident stated he/she needed the bathroom and thought he/she could make it without assistance. The resident sustained a moderate sized hematoma with ecchymosis to the mid frontal. The intervention following the incident was "frequent checks with question need of BRP (bathroom privileges)". According to the 10/12/16 care plan the resident was on prompted toileting as of 10/18/16 and facility fall protocol			

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	in place on 10/18/16 already directed staff to provide frequent checks. A resident encounter form dated 10/24/16 revealed the resident with poor safety awareness and had at least 2 falls since admission due to self-transfer attempts. The resident had a large hematoma to the forehead and bruising. The resident had debility and weakness with risk of falls. Nursing progress notes dated 10/25/16 at 12:14 p.m. revealed the resident was lethargic and weak and unable to sit up unassisted. The resident went to ER for evaluation. The resident's blood pressure was 110/50, pulse 50, respirations 16 and temperature 99.4 degrees. A hospital discharge summary dated 10/27/16 revealed the resident was admitted to the hospital for altered mental status, elevated blood pressure and hyperkalemia. Dialysis helped the hyperkalemia and blood pressure. The resident's mental status improved. The resident also had bradycardia (low heart rate) and the medication metoprolol (for blood pressure) was held due to the bradycardia. The resident discharged back to the facility. A nurses note late entry dated 10/27/16 at 4:30 p.m. revealed the resident returned to the facility. An IR dated 10/28/16 at 8:10 p.m. revealed staff found the resident lying supine on the floor in the hallway. The resident stated he/she heard his/her niece crying and went to help. The resident complained of right hip pain. Staff notified the physician and the resident transported to ER for evaluation. On 11/17/16 at 3:12 p.m. Staff D LPN stated the resident stood up and walked to the hallway and fell. The resident			

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	complained of right hip pain so he/she was sent to ER and they found out the resident had a fracture. Staff D stated the resident would get up without assistance. The resident had mental status changes and would get up and fall. When asked what staff would do to prevent the resident from falling, Staff D stated they would check on the resident often. She didn't know when staff last saw the resident. On 11/17/16 at 3:35 p.m. Staff G CNA stated Resident #1 was in bed so he put 2 residents to bed. Then he went to another room for a few minutes and then he stopped to talk to Staff D. That is when an agency staff (Staff FF) told him Resident #1 was in the vestibule area between the front door and the nurse's station. The resident heard kids crying and tried to find them. He stated he probably saw the resident 10 or 15 minutes before the incident in bed asleep. He stated the resident self-transferred in the past and did not use the call light or wait for help. The resident fell another time in the bathroom. Staff G went in to see if the resident wanted to get ready for bed and he found him/her on the bathroom floor with a mark on his/her forehead. He stated he didn't remember when he saw the resident last prior to that fall. When asked what might prevent the incident, Staff G stated alarms. He stated he usually checked on the resident every half hour. On 12/19/16 at 11:40 a.m. Staff FF LPN stated she worked on another hall when she heard the door alarm to the outside sound. She answered the alarm and found the resident on the floor in the entryway of the facility. The resident was inside the facility. Hospital progress notes dated 10/29/16 revealed the resident admitted to the hospital after a fall and sustaining a right intertrochanteric femur fracture. The resident reported pain to the right hip. The plan was to			

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	discuss the resident's case with Internal Medicine. Due to all of the comorbidities and frail state, the physician documented that he felt surgery was too risky for the resident and the rate of mortality would be high. Hospital progress notes dated 10/31/16 revealed hospice was contacted. The resident would not undergo surgery due to the severe risk of mortality with any surgical option. A death certificate revealed the resident passed away on 11/9/16 due to complications of right hip fracture. The manner of death was "accident". 5. A MDS dated 8/11/16 assessed Resident #7 with a BIMS score of 13 (cognitively intact). The MDS did not identify any behavior symptoms. The resident required extensive staff assistance with bed mobility, transfers and toileting. The resident did not ambulate. The resident had functional limitations in range of motion in the upper extremities. The resident used a wheelchair for mobility. The resident had diagnoses that included: Alzheimer's disease. The MDS did not identify the resident with skin tears. A care plan completed on 5/11/16 revealed the resident transferred with the EZ stand and assistance of one staff for all transfers. The care plan also contained an intervention created on 11/30/15 directed staff to use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. Skin Tears During Transfers: Nursing progress notes dated 7/3/16 at 7:57 p.m. revealed a CNA transferred the resident to the bathroom on the EZ stand. The resident scraped the left elbow on			

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	the wall resulting in a 1 cm. by 2.5 cm. partial thickness wound on the left elbow. Staff cleansed the area with normal saline and applied a Tegaderm (transparent) dressing. They notified the physician. The family was present when the incident occurred. Nursing progress notes identified the left elbow healed on 7/12/16 at 4:08 p.m. Nursing progress notes dated 7/16/16 at 6:01 a.m. revealed a CNA noted bleeding to the left elbow after an EZ stand transfer resulting in a 3 cm. skin tear. Staff cleansed the area with normal saline, approximated the area with steri-strips and applied a Tegaderm (transparent) dressing. They notified the physician and family. The facility documented the area as healed on 7/26/16 at 9:56 a.m. Nursing progress notes dated 10/31/16 at 6:48 p.m. revealed the resident's left elbow bumped against the doorway to the bathroom resulting in a 1 cm. by 0.4 cm. partial thickness wound. Staff applied a Tegaderm dressing. The resident's family was present when the incident occurred and staff notified the physician. The facility documented the left elbow as healed on 11/22/16 at 2:41 p.m. The care plan failed to identify any change or additional interventions to assist with the prevention of further injuries to the elbows during transfers. Observation showed on 11/17/16 at 1:46 p.m. the resident transfer from the wheelchair to bed with the EZ stand and one staff 6. MDS dated 11/10/16 revealed Resident #2 had diagnoses of Alzheimer's dementia, depression, and osteoarthritis. The MDS revealed the resident displayed impaired short and long term memory. The MDS			

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	documented the resident required extensive assistance of one staff for transfers and toilet use, and experienced unsteady balance when transferred or changed positions. The care plan dated 6/24/13, and updated on 11/6/14, documented the resident had a history of falls, and impaired communication and cognition. The care plan directed staff to do the following: a. Place call light in reach b. Use EZ stand for transfers c. Follow falling star protocol d. Position resident in areas of staff supervision at times of increased restlessness e. Provide reminders for resident to stay seated and use call light for assistance A review of incident reports and the nurse's progress notes revealed the resident had falls on the following dates: a. 7/24/16 - found on the floor in room b. 12/8/16 - slid out of wheelchair onto the floor. The social service progress notes 8/30/16 at 3:28 p.m., revealed the resident spoke little English. On 11/17/16 at 9:52 a.m., the notes revealed resident cried and wept loudly, and felt depressed. The fall assessment completed on 11/30/16, indicated the resident was at risk for falls. During initial tour 12/19/16 at 9:50 a.m., Staff I, Registered Nurse/MDS Coordinator stated Resident #2 had a star symbol taped to the doorframe outside the resident's room. Staff I reported the symbol indicated the resident was at risk for falls, and the resident had fallen in the past month.			

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	During continuous observation on 12/21/16, the following occurred: a. At 4:30 p.m., the resident found sitting on the toilet in the bathroom and crying loudly. The resident had an EZ stand sling wrapped around the backside, and under each arm. The sling straps were attached to the EZ stand, and the EZ stand device was positioned in front of the resident. The resident's arms stretched upward, and the sling remained attached to resident and the EZ stand. The resident could not reach the call light cord by the wall in the bathroom. A visitor in the room reported 2 Certified Nursing Assistants (CNA) had placed the resident in the bathroom 10 minutes prior to when the surveyor entered the room. a. At 4:35 p.m., the resident continued to cry loudly, but due to a language barrier, not able to comprehend what the resident said. b. At 4:38 p.m., Staff F, CNA, walked down the hall past the resident's room. The resident sat on the toilet in the bathroom and cried. c. At 4:40 p.m., Staff G, Licensed Practical Nurse (LPN), stood by the medication cart parked four doors down the hall from the resident's room. The resident continued crying. d. At 4:42 p.m., Staff F walked down the hall past the resident's room. e. At 4:46 p.m., Staff G, entered the resident's room, opened the bathroom door, and asked the resident if he/she wanted to get off the toilet. Staff G placed the call light on, told the resident she would tell a CNA, and then left the room. f. At 4:47 p.m., Staff H, CNA entered the resident's room. The resident cried. Staff H told the resident she had to get assistance. The resident sobbed and asked "Soon?"			

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	Staff H acknowledged it would be soon, and left the room. g. At 4:48 p.m., Staff H and Staff F entered the room and assisted the resident. During an interview on 12/21/16 at 4:50 p.m., Staff G, LPN, reported she had gone into Resident #2's room to get something, and found the resident on the toilet in the EZ stand. Staff G stated she didn't know the facility's practice for EZ stand use, but thought when staff used the EZ Stand, 2 staff were required. During an interview on 12/21/16 at 5:15 p.m., Staff H, CNA, reported she had placed the resident on the toilet, but needed assistance of two, and had to wait for assistance to get the resident off the toilet. During an interview on 12/22/16 at 9:30 a.m., Staff D, CNA, stated residents should not be left in an EZ stand alone because the resident could fall. In an interview 12/22/16 at 8:50 a.m., Staff I, MDS Coordinator, stated when staff used an EZ stand, she expected staff not leave the resident in an EZ stand unattended. Staff I reported if staff left a resident unattended in an EZ stand, it would be unsafe for the resident. In a policy and procedure for EZ stands, dated 5/2016, directed staff to do the following: a. Move the resident to the desired location b. Lower the resident until fully lowered to bed, chair, or toilet c. Unhook the harness d. Move the unit away from the resident.			

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	7. The MDS dated 11/18/16 documented diagnoses that included anxiety, depression, diabetes and heart failure for Resident #9. The same MDS documented A Brief Interview of Mental Status (BIMS) score of 14 (intact cognition), required limited assistance with transfers and ambulation, utilized a wheelchair for locomotion, did not ambulate in the 7 day assessment period and had 2+ falls without injury since the last MDS completed in the prior 92 days or less. The care plan problem initiated 6/17/13 identified the resident with a potential for falls related to impaired mobility, incontinence, medication use, debility, osteoporosis and history of fractures of the right ankle, the left tibia and fibula and C1 (neck) fracture and directed staff to answer call lights promptly at night. The Care Plan also directed staff to provide 1 assist for ambulation and provide patient education related to safe sitting and standing when appropriate, provide supervision to limited assistance with transfers as needed/requested and revealed the resident also self-transfers. The pocket care guide carried by staff identified the resident required 1 assist with activities of daily living (ADL ' s), transfers and ambulation and directed staff to check on the resident before and after meals as needed on all shifts to offer assistance with transfers, toileting and ADL ' s and identified the resident has poor vision. The incident Report dated 11/11/16 at 6:40 AM documented staff found the resident on the floor by the bed. The report documented the resident transferred themselves from the bed to the wheelchair, slipped to the floor and landed on his/her buttocks. The resident sustained no injury and the facility installed an anti-			

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	rollback device on the wheelchair. The Incident Report dated 11/13/16 at 2315 (11:15 PM) documented staff found the resident sitting on the floor with his/her back against the bed. The resident appeared sleepy and stated s/he did not know what happened. The resident had no injury. The incident report identified the resident ' s call light was on at the time of the occurrence. The care plan intervention added 11/13/16 directed staff to answer the resident ' s call light promptly at night. The Occupational Therapy Discharge Summary dated 12/9/16 documented the resident received OT services 11/21-12/9/16 and identified the resident required assistance of 1 at all times for ADLs, transfers and mobility. The Incident report dated 1/2/17 at 22:10 (10:22 PM) documented staff found the resident face down on the floor of his/her room with legs extended. The resident tried to self-transfer from the wheelchair to the recliner and sustained a laceration to the right forehead. Staff called 911 and the resident transferred to the emergency room. The Report identified the new intervention: assure all resident needs met before leaving the room, i.e. assisted to the toilet, offer water or snack for hunger. The Progress Notes dated 1/3/17 at 5:00 AM documented the resident returned from the hospital with 6 sutures to the right forehead to close the 4.5 cm laceration. The resident was educated to use the call light for assistance and placed within reach.			

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	Observation on 1/12/17 at 11:10 AM revealed staff could not locate the resident. Staff ZZ, pool CNA, located the resident in his/her bathroom. The resident had self-transferred to the toilet. Staff ZZ stated she had just returned from break. Prior to going to break Staff ZZ stated the resident had been sitting in his/her recliner. Staff ZZ stated other staff had told her the resident does self-transfer and to check on him/her frequently. 8. The MDS dated 11/11/16 documented diagnoses that included breast cancer, psychotic disorder, Non-Alzheimer ' s dementia and inflammation/infection of an artificial knee joint for Resident #43. The same MDS documented a BIMS score of 6 (moderate cognitive impairment) and revealed the resident required extensive assistance for transfers, ambulation, hygiene and toileting, and had limited functional range of motion in one leg. The MDS identified the resident was only able to move from seated to standing position, walk or turn around with staff assistance, utilized a wheelchair for mobility and had 2+ falls without injury since the last MDS completed in 92 or less days ago. The care plan problem dated 5/20/14 and revised 2/25/16 identified the resident had impaired cognitive functioning related to vascular dementia with episodes of confusion, poor memory recall and impaired temporal orientation. The care plan directed staff to cue, reorient and supervise the resident as needed. The care plan problem initiated 3/28/14 and revised on 8/18/16 identified the resident ' s self-care deficit related to multiple medical problems and debility and directed the resident uses a wheelchair as primary means of locomotion, prefers to sleep in the recliner and required extensive assistance of 1 for all transfers. The care plan intervention dated 3/28/14 identified the resident as			

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	independent with controlling the electric recliner. The care plan problem dated 3/28/14 and revised on 3/9/15 identified the resident as at risk for falls related to a history of falls and previous fracture of the right humerus, osteoarthritis and osteopenia and directed staff to assure the resident needs are met before leaving the room, i.e. offer toileting, offer water for thirst and snacks for hunger, be sure the call light is in reach and encourage the resident to use it and to provide prompt response to all requests for assistance as appropriate. The Incident Report dated 11/10/16 at 9:20 PM documented the resident ambulated independently to the bathroom and fell to the floor although a pool CNA present in the room. Staff placed a " do not fall " sign on the resident ' s bedside table as an intervention after the incident. The Incident report dated 12/8/16 at 10:30 PM documented staff found the resident on the floor between the recliner and the bed with his/her back against the recliner holding on to the side rail and legs under the bed. The resident sated s/he attempted to go from the recliner to bed. The Incident Report listed the intervention to check the resident every 2 hours to see if assistance needed to move or change positions. The Incident Report dated 12/23/16 at 3:45 AM documented the resident found lying on his/her back in the bathroom with legs extended. The resident stated s/he want to go to the bathroom independently. The resident sustained a skin tear to the left buttock which measured 0.5 cm x 0.5 cm and a skin tear to the right buttock which measured 1.0 cm x 1.0 cm. The intervention after the incident was documented as a sign			

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	posted in visible sight which said " DO NOT FALL, CALL FOR ASSIST!! " The Physical Therapy (PT) Discharge Summary dated 12/26/16 documented the resident received treatment 7 days from 12/9-12/26/16. The resident refused Tinetti balance testing and last Summary Since Last Progress Report documented the resident continued with 1 person assist and continued with fall even with PT intervention. The Incident Report dated 12/27/ 16 at 5:20 AM documented staff found the resident lying on the floor in front of the recliner with his/her head towards the recliner and the walker laying on top of the resident. The resident right leg below the knee twisted at a 90 degree angle. Staff called 911 and the resident left the facility by ambulance at 5:45 AM. During interview on 1/12/16 at 11:54 AM Staff UU, LPN stated she found the resident on the floor on 12/27/16. She stated she had been shocked to see the resident ' s right lower leg in the very abnormal position and immediately called 911. Staff UU stated she did not do an assessment of the resident ' s room at the time of the incident, could not recall if the resident ' s electric recliner had been up or down and could not recall if the resident ' s call light on. Staff UU stated the resident was often non-compliant with using the call light and frequently self-transferred. She did not know when the resident had last been observed by staff prior to the incident. Staff UU stated she knew the most important thing had been to get the resident to the hospital as quickly as possible. The Hospital Trauma Services Discharge Summary documented the resident sustained a right tibia and fibula fracture, a fracture of the right ankle which required			

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	surgical repair as well as 2 small acute subdural hematomas. The resident returned to the facility on 1/3/2017. During an interview on 1/12/17 at 2:40 PM, the DON stated neither she nor staff completed an investigation into the resident ' s fall on 1/27/16. When she came into work that morning around 8:00 AM she did go down to the resident ' s room and sit in the recliner to check out the surrounding, but did not interview staff on duty at the time of occurrence. The DON stated the recliner was in regular position when she went to the room but did not know the position of the recliner at the time of the incident. Observation on 1/12/17 at 9:00 AM revealed the resident in bed with half side rails up and a lipped mattress on the bed. Resident had a CAM boot on the right lower leg. The resident ' s call light lay across the resident ' s recliner well out of resident reach and the bedside table, which contained a sign which said " DO NOT FALL " as well as the resident ' s water pitcher, across the room by the divider curtain. The sign on the wall to the resident ' s left side read " DO NOT FALL, CALL FOR ASSIST!! " 9. The MDS dated 11/24/16 documented diagnoses that included Alzheimer ' s disease, seizure disorder and blindness in one eye and low vision in the other for Resident #45. The same MDS documented a BIMS score of 9 (moderate cognitive impairment) and revealed he/she required limited assistance for transfers, ambulation, toileting and hygiene. The MDS also documented the resident, utilized a wheelchair and had no falls since the last MDS completed 92 days or less ago and received anticoagulant medications 7 of 7 days of the assessment period.			

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	The care guide carried by the staff documented the resident required extensive assistance of 1 staff for pivot transfer and utilized a wheelchair for mobility. The guide directed staff to place the call light on the right side as the resident was blind in the left eye, do not leave the resident alone in the bathroom and move the electric recliner remote control out of resident reach when he/she sat in it. The progress notes dated 12/25/16 at 20:43 documented staff saw the resident lying on the floor with his/her head resting on the bottom of the recliner and legs straight out. The resident sustained a skin tear on the right elbow and a laceration on the right side of the head. The Incident Report dated 12/2516 documented the intervention to place the resident's call light on the right side when possible due to blindness in the left eye and staff educated the resident use the call light. The Incident Report dated 12/27/16 at 8:50 AM documented staff found the resident lying supine in front of the recliner with the wheelchair located a few feet away. The wheelchair brakes were not locked. The resident could not state what s/he had been doing prior to the fall because of chronic decreased cognition. At 9:40 AM staff noted a red area on the resident ' s scalp just above the right ear. The progress notes entry dated 12/27/16 at 13:15 (1:15 PM) documented staff found the resident on the floor in front of the recliner in a supine position. The resident ' s wheelchair located not far away and tipped on its side. The resident could not relate what happened due to longstanding cognitive issues. The progress notes entry at 12:21 (1:21 PM) documented the resident had a reddened area above the right ear, but unclear whether this it was a new area or one from a previous fall.			

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	Review of the care plan revealed no new intervention(s) put into place after this incident. The Incident Report dated 12/31/16 at 1400 (2:00 PM) documented staff found the resident on the floor of their room with their head under the wheelchair and their legs outstretched in front. Resident stated s/he had been " picking up the place " but staff noted no trash or clutter noted on the floor. The resident sustained a superficial scrape down the middle of the back. The Incident Report documented the intervention to keep the resident ' s room/floor clean and instructed the resident to call for assistance when things are on the floor so staff can pick them up. The progress notes entry dated 12/31/16 at 16:28 (4:28 PM) documented the resident ' s spouse expressed concern with the resident ' s fall and altered mental status. Staff contacted the resident ' s physician and obtained an order to a urinalysis (UA) and to draw a complete blood count and basic metabolic profile today rather than 1/3/17. The Incident Report dated 1/3/17 at 7:50 AM documented the resident attempted to self-transfer from the wheelchair to the recliner and fell onto their buttocks. The resident had no noted injury, but the resident's blood pressure (BP) measured 160/86. The Incident Report documented as an intervention to monitor and report potential seizure activity. The progress notes entry dated 1/3/17 at 2:41 PM documented staff implemented a nursing order to check the resident ' s BP 2 times a day for 3 days and then fax those results to the physician. The progress notes entry dated 1/3/17 at 6:31 p.m. documented staff received an order to administer Macrobid (a urinary tract anti-infective medication) 100			

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	milligram (mg) 2 times a day for 10 days. The Incident Report dated 1/8/17 at 9:00 AM documented staff found the resident on the floor in front of the recliner. The resident ' s electric recliner elevated forward slightly and the resident slid out and landed on his/her buttocks. The resident sustained no injury. The Incident Report documented the facility implemented an intervention to place a non-skid pad in the recliner. The Incident Report dated 1/8/17 at 2000 (8:00 PM) documented staff found the resident lying on the floor on their right side next to the bed. Resident stated s/he attempted to go from the recliner to the bed and fell. The resident sustained no injury. The Incident Report documented the staff implemented an OT evaluation and treatment as an intervention after the fall. Observation on 1/18/17 at 1:22 PM revealed the resident sat in his/her recliner with feet up. The remote control for the recliner placed out of resident ' s reach. The resident ' s call light was fastened on the resident ' s left side near his/her hand. The facility ' s Falls Prevention Procedure dated 11/2013 directed the following: A fall committee consisting of the Administrator, DON, and quality assurance (QA) nurse will review the incident report. The review will include the environment where the fall took place, evaluation of the interventions in place, ideas for other interventions that may be appropriate [and] provide education to staff. During an interview on 1/12/17 at 4:00 PM the DON, she stated the current Incident Report form has a section for investigation of the fall as well as witness statement			

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	forms, but staff had failed to complete them. She stated she had assumed the DON position at the end of November, 2016 and had plans to change the falls investigations and analysis but has not implemented them at this time because she had been directed by higher management to make changes a little bit at a time. She also stated the facility does not have a fall committee and no formal system to review falls and assess the appropriateness or efficacy of interventions. She stated the staff has a list of interventions that can be implemented and are taught to put one into place after each fall. Review of the list of falls that occurred in the facility 12/1/16 through 1/10/17 documented 35 residents sustained a total of 69 falls in this time frame. **FACILITY RESPONSE:**			

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58.19(2)(j)	**481—58.19(135C) Required nursing services for residents.** The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: **58.19(2)** *Medication and treatment.* *j.* Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III) [**ARC 1398C**, IAB 4/2/14, effective 5/7/14; **ARC 2560C**, IAB 6/8/16, effective 7/13/16] **DESCRIPTION:** **DESCRIPTION:** Based on observation, record review and staff interview, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 7 of 7 residents reviewed. Resident #2, #3, #5, #7, #11, #17, and #21. Resident #5 experienced symptoms of stroke that the facility failed to act on in a timely manner. Resident #2, Resident #11 and Resident #3 fell and bruised their faces. The facility failed to assess and document the bruising. Resident #7 had an open area to his/her bottom that the facility failed to measure or document a	**I**	**$5,000** **Held in Suspension**	**On Receipt**

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	description of. The facility failed to follow up on Resident #5's skin impairment. Resident #17 had cancer and pain. The resident stated the facility failed to administer pain medications in a timely manner. Resident #21 fell and fractured his/her upper arm (humerus) and the facility failed to document an ongoing assessment. The facility failed to provide a follow up assessment. Facility census was ninety-three (93) residents. Findings include: 1. A Minimum Date Set (MDS) assessment tool dated 3/31/16 assessed Resident #5 with a BIMS score of "5" (severe cognitive impairment) The resident had behavior symptoms of verbal and other behaviors 1 to 3 days out of 7 and did not reject care. The MDS documented the resident required extensive staff assistance with bed mobility, dressing and eating and total assistance with transfers, toileting, personal hygiene and bathing. The MDS also documented Resident #21 did not ambulate and had functional range of motion limitations of one lower extremity, was frequently incontinent of bowel and bladder, and at risk for pressure sores and the resident had pressure sores. The MDS did not identify moisture associated skin damage (MASD) and revealed the resident had diagnoses that included: peripheral vascular disease (PVD) and fracture of the right femur. The resident admitted to the facility on 6/10/11. Stroke Nursing progress notes dated 7/28/16 at 8:31 p.m. and documented by Staff C RN revealed the resident's granddaughter informed the nurse that the resident had right side facial drooping and could not speak. The resident appeared sleepy. The resident looked at Staff C when staff spoke to him/her. The resident attempted to			

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	speak to answer questions but could not say any actual words. The right side of the face had drooping and the right grip was weaker. The resident could move extremities. Temperature was 98 axillary, pulse 84, respirations 16 and blood pressure 128/72. The next nursing progress note entry dated 7/29/16 at 12:45 a.m. and documented by Staff AA LPN revealed Staff C informed her of the resident's symptoms at 12:30 a.m. Staff AA observed the resident lying in bed awake and alert with right side of face drooping. The resident could usually swallow a pill whole. Staff AA had to crush the resident's 12 a.m. Norco and the resident could not keep it in his/her mouth. Water and parts of the pill ran out of the right side of the resident's mouth. The resident could follow the nurse with his/her eyes. The resident could not speak. The resident could not grasp with the right hand. The resident's pupils reacted to light. Staff AA notified the resident's daughter at 1 a.m. who gave the OK to notify the physician. Staff AA called the physician's answering service at 1:10 a.m. with no answer. At 1:40 a.m. the ARNP called and gave the OK to transport the resident to ER. At 2:16 a.m. the ambulance arrived and transported the resident to the hospital. Hospital ED (emergency department) HPI (history of present illness) comments, dated 7/29/16 at 2:56 a.m. revealed the resident presented from the nursing home for evaluation of stroke-like symptoms and was noted to develop an acute onset of expressive aphasia with right sided facial droop and right upper extremity weakness around 8:30 p.m. last night. The facility did not send the resident to the ED at that time. Nursing staff at the facility reportedly noted a persistent expressive aphasia and facial droop around 12:30 a.m. this morning as the resident had difficulty taking his/her pills at that time.			

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	Therefore EMS (emergency medical services) was finally called around 2 a.m. to transfer the resident to the ED for further evaluation. ED provider notes dated 7/29/16 at 5:26 a.m. revealed the resident continued to have apparent neurological deficits including facial droop and aphasia. The physician suspected the resident's symptoms were related to an acute stroke though the onset and progression of the symptoms. The resident presented well outside the window for any emergent treatment for an acute stroke as symptoms started around 8:30 p.m. yesterday evening. The resident admitted to the hospital for care. A hospital history and physical identified the resident's principal problem as "acute ischemic stroke". On 11/22/16 at 2:38 p.m. Staff C RN stated the resident started having symptoms on the 2 p.m. to 10 p.m. shift. The resident was very tired and exhibited unclear speech. Staff C thought it may have to do with the resident being tired. Staff C notified the charge nurse Staff M LPN. The resident's vitals were fine and they continued to monitor the resident. Staff C stated it was up to the charge nurse to make the decision to send the resident to the hospital. On 11/23/16 at 9:28 a.m. Staff M LPN stated she worked on the skilled unit that night. Staff M confirmed she was the charge nurse that shift. Staff M stated a resident readmitted and she helped that resident get to his/her room when she was told Staff C needed her. Staff M asked what was wrong and the resident's family stated the resident was not acting right. Staff M stated she then let Staff C know if she needed help to let her know and she went back to the resident that just returned to the			

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	facility. Staff M stated she glanced in the room and Staff C was in there and that's when she told her to let her know if she needed help. She didn't give Staff C any directives on what to do for the resident and she never heard anything more from Staff C. No one told her any specifics other than the resident wasn't acting right. On 12/19/16 at 12:16 p.m. Staff AA LPN stated she came on duty after midnight and Staff C told her the resident's granddaughter had concerns that the resident had signs and symptoms of stroke since 8 or 9 p.m. Staff AA immediately went to the resident's room and the resident had mumbled speech with right facial drooping. Staff AA thought the resident had a stroke so she sent the resident to the hospital. Staff AA stated from what she saw, the resident should have transferred to the hospital a lot sooner. On 12/20/16 at 1 p.m. during phone exit the Administrator identified Staff AA as a disgruntled employee with credibility issues. Skin Impairment Nursing progress notes dated 7/13/16 at 9:48 p.m. revealed a CNA reported the resident had a moderate amount of red blood in his/her brief that appeared to come from the vagina. Assessment of the area revealed a small amount of blood from small nodules and lumps on the labia fold. Staff cleansed the area and patted dry. The resident voiced discomfort to the area. The record lacked follow up of the area. Nursing progress notes dated 7/29/16 at 2:16 a.m. revealed the resident transported to the hospital with stroke symptoms.			

Facility Administrator Date

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Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC#6410				**Date: Jan. 13, 2017**
Fountain West Health Center		**Survey Dates: Nov 5,17 22,23,28-30 & Dec. 5-7,20 2016 & Jan. 11-24**		
1501 Office Park Road				
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		Class	**Fine Amount**	**Correction date**
	Hospital records dated 7/29/16 at 2:58 p.m. revealed hospital staff assessed the resident with Stage 2 wounds on the perineal area. The resident had multiple open areas on the outer and inner labia and urethral opening. On 11/28/16 at 4:05 p.m. the Director of Nursing (DON) stated she did not find the facility followed up on the 7/13/16 observation and that the resident did not have a physician encounter that addressed it. 2. An MDS dated 9/17/16 assessed Resident #2 with a brief interview for mental status (BIMS) score of "5" (severe cognitive impairment). The resident had the following indicator of delirium that fluctuated through the day: inattention. The resident had no behavior symptoms identified. The MDS documented the resident required limited staff assistance with bed mobility, transfers and ambulation and extensive staff assistance with toileting, dressing and personal hygiene. A "balance during transitions and walking" test identified the resident as not steady and only able to stabilize with staff assistance. The resident used a walker and wheelchair for mobility. The resident was occasionally incontinent of bladder. The resident had diagnoses that included dementia. An incident report dated 10/16/16 at 5:15 a.m. revealed the resident stated he/she came out of the bathroom and fell. Staff found the resident sitting on his/her bottom on the resident's room floor. The resident said he/she hit their head on the edge of the bed. Staff applied an ice pack to the head. The resident received a hematoma to the right forehead and abrasion to the buttock. The incident report did not identify an intervention following the incident. Nursing progress notes dated 10/16/16 at 9:16 a.m. revealed the resident transported to ER for evaluation.			

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	A physician encounter form dated 10/17/16 at 4:51 p.m. revealed the resident was sent to ER on 10/16/16 after a fall. The resident had bruising above and below bilateral eyes as well as the right forehead. ER evaluated the bruising. The bruising was described as follows: Examination of the head and face revealed hematoma around the bilateral eyes and right forehead and tenderness over the right frontal area. The right eyelid showed swelling of the upper eyelid and extensive bruising around the bilateral eyes. The facility failed to document any bruising on the face. Observation showed 11/16/16 at 11:07 a.m. the resident in bed. The resident had visible bruising around both eyes. 3. An MDS dated 9/15/16 assessed Resident #11 with a BIMS score of "5" (severe cognitive impairment). The resident required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, and personal hygiene. The resident did not ambulate. The resident had functional range of motion (ROM) limitations of the upper and lower extremities. The resident used a wheelchair for mobility. The resident had diagnoses that included: dementia and stroke. The resident had two or more falls without injury since the previous assessment. An incident report dated 10/17/16 at 7:20 p.m. revealed staff found the resident laying on the right side in the central hallway. The resident had a large bump on the forehead and a bloody nose. The resident complained of back pain. The alarm sounded when the resident fell. On 11/23/16 at 1:55 p.m., Staff K LPN stated the resident was in the central hallway and fell out of the wheelchair.			

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	She stated there was a family visiting another resident in the central hall and they alerted staff to the resident's fall. No staff heard the resident's wheelchair alarm. and found the resident lay face first on the ground. Staff K called the ambulance and the resident transported to ER for evaluation. Staff K stated after the incident the resident had black eyes. Nursing progress notes dated 10/18/16 at 12:08 a.m. revealed the hospital called and informed the facility the resident had a UTI (urinary tract infection) and the resident would return with an order for Keflex (antibiotic) to treat the UTI. The head CT and the chest x-ray were OK. Nursing progress notes on the same date at 1:48 a.m. revealed the resident returned to the facility and had bruising to the forehead and face. There was no further documentation regarding the bruising. Observation showed on 11/23/16 at 1:10 p.m. Staff L CNA transferred the resident to the toilet via the EZ stand. The alarm sounded when Staff L assisted the resident to stand. Staff L stated she took care of the resident on 10/17/16 and the resident fell after she left. The next day the resident had 2 black eyes. On 11/28/16 at 4:05 p.m. the DON stated she could not find any documentation regarding the resident's facial bruising after readmission from ER. 4. An MDS dated 7/21/16 assessed Resident #3 with a BIMS score of 8 (moderate cognitive impairment). The resident required extensive staff assistance with bed mobility, dressing, toileting, personal hygiene and bathing. The resident required limited staff assistance with bathing. A "balance during transitions and walking" test identified the resident as not steady but able to stabilize with staff assistance and revealed the resident used a walker and wheelchair for mobility. The MDS			

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	identified the resident received daily anticoagulant medication. An IR dated 11/22/16 at 5:30 a.m. revealed a fall in the resident room. Staff found the resident on the floor next to the bathroom. The resident could not explain what occurred. The IR identified the resident had previously been anxious. The resident sustained a bump to the forehead that measured 2 cm. by 2 cm. The intervention following the incident was to answer the resident promptly when he/she called. (Already in place) and a PT/Occupational therapy (OT) screen. A hospital report dated 11/23/16 revealed the resident fell 3 times in the past 3 days. The resident sustained arm lacerations to both arms and a left sided forehead hematoma. The report identified a left wrist skin tear and right bicep skin laceration. Observation: Observation showed on 11/28/16 at 11:37 a.m. the resident wheeled self with feet in the wheelchair. Observation showed a large bruised area around the left eye. When asked what happened the resident stated "it's been like that a long time." The record lacked documentation of a left black eye after 11/22/16. 5. A MDS with assessment reference date of 8/11/16 assessed Resident #7 with a BIMS score of "13" (no cognitive impairment). The MDS did not identify any behavior symptoms. The MDS documented the resident required extensive staff assistance with bed mobility, transfers and toileting, did not ambulate, was frequently incontinent of bowel and bladder, and used a wheelchair for mobility. The MDS identified the resident had			

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	diagnoses that included: Alzheimer's disease. A care plan completed 8/15/16 identified the resident with potential skin impairment related to risk factors for skin breakdown and incontinence, edema, impaired mobility and cognition, right hand contracture and noncompliance with right hand splint. The care plan directed staff to encourage and assist the resident to change position frequently, avoid lying or sitting in any one position for extended periods of time. On 11/17/16 at 9:28 a.m. observation revealed a band aide on the resident's left buttock. When staff removed the Band-Aid, there was no open or scabbed area beneath it. On the same date at 11:55 a.m., observation also revealed two scarred healed areas to the upper buttocks and an open horizontal slit at the top of the upper right buttock area. At that time, Staff T LPN confirmed the area was open and applied dermagran (for skin impairment) to the area. Observation showed on 11/28/16 at 1:48 p.m., the resident in bed on his/her back. The resident remained in a back lying position until 4:42 p.m. (3 hours) Observation revealed on 11/29/16 at 8:08 a.m. the resident up in the wheelchair. The resident remained up in the wheelchair until 1:27 p.m. when Staff Q transferred the resident to bed. Prior to transfer to bed, Staff Q checked and changed the resident. The resident had red areas on the upper buttocks. On 11/29/16 at 1:43 p.m. Staff R CNA stated she and Staff S CNA got the resident up around 7 a.m. to 7:30 a.m. and neither she or Staff S CNA did anything with the resident since they brought the resident back from breakfast and started showers. This indicated the resident sat in the wheelchair approximately 6 hours.			

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	On 11/29/16 at 11:12 a.m. the resident stated he/she sat in the wheelchair all morning and he/she didn't want to sit that long. The resident stated no one offered or took him/her to the toilet since he/she got up. Documentation: Nursing progress notes dated 11/16/16 at 2:49 p.m. revealed the resident had two, small thick scar tissue areas to the upper buttocks. The entry identified superficial pinpoint areas on the scar tissue areas. The facility notified the physician and received an order for dermagran Nursing progress notes dated 11/23/16 at 1:04 p.m. revealed staff documented the resident with skin impairment of the coccyx. (No measurement or description documented). Staff applied Dermagran to the area. Nursing progress notes dated 11/30/16 identified a decrease in the size of the open area on the right gluteal. (no measurement or description) Nursing progress notes dated 12/5/16 at 11:48 a.m. identified the area as healed. On 12/7/16 at 9:10 a.m. the Director of Nursing (DON) stated the facility did not have skin sheets for the area because they only do skin sheets for pressure, stasis and arterial sores. Staff documents in the nursing progress notes. 6. An MDS dated 10/20/16 assessed Resident #17 with a BIMS score of "15" (no cognitive impairment). The resident was independent with all cares other than supervision for bathing. The resident had diagnoses that			

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	included: breast cancer with bone, liver and lung metastasis. The MDS identified the resident with frequent pain and pain that made it hard to sleep at night at a pain level of "3" on a scale of 0 to 10 with 10 being the worst imaginable pain. A care plan dated 10/27/16 identified the resident with a pain/comfort concern related to cancer diagnosis as evidence by usage of pain medication and complaints of pain. The care plan directed staff to encourage the resident to verbalize presence, type and location of pain and administer medications as ordered. On 11/29/16 at 9:08 a.m. the resident stated she waited 2 hours for a pain pill the day before yesterday. (11/27/16). The resident stated he/she pushed the call light at 7:30 a.m. to be able to get a pain pill by 8:30 a.m. The resident stated he/she didn't get the pain pill until 10:15 a.m. when she got both the long acting and short acting pain pills together. The resident stated it was hard to get the pain managed after that. The same day the resident pushed the call light at 1:30 p.m. to get his/her 2 p.m. medication and he/she didn't get it until 3:15 p.m. At 2:15 p.m. the resident pushed the call light again and a nurse aide answered it and said she would tell the nurse the resident wanted his/her 2 p.m. medication. The resident stated he/she could handle the medication 1 hour late but not longer. The resident got up and went to the big nurse's station. The resident thought he/she may pass out but the resident made it and got the medication instantly then. The November medication administration record (MAR) revealed the resident had an order for morphine sulfate 60 milligrams (mg.) SA (sustained release) every 12 hours morning and bedtime. The resident had a PRN (as needed) order for Morphine Sulfate IR (immediate			

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	release) 30 mg. every 4 hours as needed for pain. Narcotic controlled substance record identified the nurse signed out the morphine 60 mg SA on 11/27/16 at 9 a.m. and morphine IR 30 mg on 11/27/16 at 9:45 a.m., 2:30 p.m., and 6:30 p.m. 7. According to the MDS dated 11/3/16, Resident #21had diagnoses that included osteoarthritis and chronic pain. The same MDS documented a Brief Interview of Mental status score of "14" (intact cognition) and revealed the resident, required extensive assistance with transfers and ambulation, did not ambulate in his/her room or the hallway during the assessment period, utilized a wheelchair for mobility and had decreased functional range of motion in one upper extremity. The resident had no falls since the last assessment completed 92 days or less. The care plan problem revised 11/10/16 identified the resident as at risk for falls related to deconditioning and vision and hearing problems and directed staff to provide assist of 1 for transfers from bed. The care plan also directed staff to provide assist of 1 with other transfers upon request, place the call light placed within reach and encourage the resident to use it. The Incident Report dated 1/8/17 documented staff found the resident found lying on the floor on his/her left side at 5:15 PM. The resident stated he/she attempted to go to the bathroom and fell. The resident complained of pain to the left upper arm and the nurse assessed the resident had decreased range of motion in this arm. The progress notes entry in the resident's clinical record completed by Staff WW, RN, dated 1/8/17 at 8:29 PM			

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	documented the resident sustained an 8 centimeter (cm) skin tear to the left elbow and complained of pain and had limited range of motion in the left arm. The Incident Report documented the resident notified by fax if the incident. The progress notes contained no further assessment of the resident until 1/9/17 at 2:42 PM which documented the resident had a bruise and two abrasions on the left knee, in addition to the left arm skin tear. The entry documented the resident's range of motion within normal limits. The clinical record contained no further information on the resident until 1/10/17 at 1:54 PM which documented the unit secretary told the nurse the resident did not act right and seemed confused. The entry failed to contain any assessment of the resident other than vital signs and blood sugar result. Staff placed a call to the physician's office and called 911 to transport the resident to the hospital. The progress notes entry dated 1/10/17 at 8:08 PM documented the resident admitted to the hospital with a fracture of the left humerus (bone of the upper arm). During interview on 1/12/17 at 4:04 PM the director of nursing (DON) stated staff failed to continue to assess the resident post-fall and she has disciplined the nurses involved. **FACILITY RESPONSE:**			

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58.19(2)b	**481—58.19(135C) Required nursing services for residents.** The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: **58.19(2)** *Medication and treatment.* *b.* Provision of the appropriate care and treatment of wounds, including pressure sores, to promote healing, prevent infection, and prevent new sores from developing; (I, II) **DESCRIPTION:** Based on record review and staff interview, the facility failed to ensure that a resident who entered the facility without pressure sores did not develop pressure sores unless the individual's clinical condition demonstrated that they were unavoidable; and a resident having pressure sores received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for 1 of 5 residents reviewed. The facility failed to ensure Resident # 5's cast padding was smooth without rolling/bunching on 6/21/16 resulting in a deep tissue injury (DTI) to the right heel. ER (emergency room) notes dated 6/25/16 identified the resident with a new decubitus on the right foot developed secondary to pressure at the cast site due to the leg hanging in the dependent position. After the cast was removed on 7/15/16, the facility assessed the pressure sores on the right foot. There was no further documentation of assessment of the sores. The resident transferred to the hospital 7/29/16. Staff initialed they	**I**	**$3,000** **Held in Suspension**	**On Receipt**

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	provided the ordered Betadine treatment to the right foot 8 out of 14 days. Facility census was ninety-three (93) residents. Findings include: 1. A Minimum Data Set (MDS) assessment tool dated 3/31/16, assessed Resident #5 with severe cognitive impairment and documented the resident displayed behavior symptoms of verbal and other behaviors 1 to 3 days out of 7, but did not reject care. The resident required extensive staff assistance with bed mobility, dressing, eating and personal hygiene. The resident required total assistance with transfers, toilet use and bathing. The resident did not ambulate. The resident had functional range of motion limitations of one lower extremity. The resident was frequently incontinent of bowel and bladder. The MDS identified the resident at risk for pressure sores and the resident did not have pressure sores. The MDS identified the resident with diagnoses that included: peripheral vascular disease (PVD) and fracture of the right femur. The resident admitted to the facility on 6/10/11. An MD/nursing communication form dated 6/15/16 at 10:44 a.m. revealed staff notified the resident's primary physician that the resident saw the orthopedic (ortho) physician on 6/14/16 and had the right lower extremity (RLE) cast removed and the resident now wore a splint on the RLE. The resident continued non-weight bearing status. The resident had an order for topical use of hydrocolloid dressing and cast padding to the toes of the right foot due to the use of the cast. Staff documented the treatment was no longer needed since ortho removed the cast. The skin to the toes was intact. The physician signed the order 6/15/16 and agreed to the discontinuation of the hydrocolloid dressings and cast			

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	padding. An MD/nursing communication form dated 6/21/16 at 10:24 a.m. revealed Staff Y LPN (licensed practical nurse) asked Staff Z LPN to assess skin breakdown to the right heel. Staff Y removed the compression wrap used to hold the half cast to do a skin assessment. The cast padding was not smooth and was rolled up in places, especially the heel and achilles area. Staff Z assessed a DTI measuring 2 cm. (centimeter) by 2 cm. and a 0.7 cm. by 0.6 cm. wound with dry yellow exudate just superior to it. Assessment showed extensive desquamation of the skin on the right foot and ankle. The resident did not complain of pain. Staff Z instructed Staff Y to place new cast padding to the half cast and a dressing to the heel. Staff Z requested the following treatment for the wounds: Cleanse wounds at right heel/achilles area with soap and water, rinse and pat dry. Apply skin prep to surrounding skin allow to dry. Cover with foam dressing and change every 4 days and as needed. The ARNP (advanced registered nurse practitioner) agreed to the order. On 11/29/16 at 10:24 a.m. Staff Y LPN stated on 6/21/16 she discovered the resident had skin breakdown so she got Staff Z to check the areas and that was her only part in that incident. On 11/29/16 at 5 p.m. Staff Z LPN stated the cast padding was rolled up and that could be the cause of the resident's DTI discovered on 6/21/16. A physician encounter form dated 6/21/16 at 11:55 a.m. identified the ARNP saw the resident for an acute wound to the right heel. The resident had a history of right distal femur fracture with secondary pain. The ARNP identified the acute wound on the right heel as a pressure ulcer			

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	with a soft padded dressing over it. The ARNP identified the heel as difficult to float. The resident was referred to the wound clinic for follow up. Nursing progress notes dated 6/21/16 at 4:30 p.m. revealed the facility attempted to schedule an appointment at the wound center. The wound center stated the first they could see the resident was in 1 to 2 months. Nursing progress notes dated 6/22/16 at 1:11 p.m. revealed the resident's family expressed they did not feel the facility cared for the resident's leg and heel appropriately and tried to take the resident to the orthopedic physician via car and could not get the resident in the car due to immobility to bend leg. An x-ray report identified an x-ray of the RLE completed on 6/22/16 showed no changes from 3/20/16 x-ray. Nursing progress notes dated 6/23/16 at 8:55 a.m. revealed the facility received a phone call from the orthopedic physician office for the resident to come to the office that afternoon to get the RLE recasted. Nursing progress notes dated 6/24/16 at 2:52 p.m. revealed the new cast contained a heel cut out due to the DTI and Stage 3 ulcer. Edema to the heel caused compression against the cast edges especially at the achilles area. The facility notified the physician on 6/24/16 at 3:56 p.m. of the edema. The physician directed staff to elevate the leg as able. An ER (emergency room report) dated 6/25/16 at 9:28 p.m. revealed the resident came to the ER for a cast problem involving an issue with swelling in the right heel			

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	and the cast pressing into it. The report identified an ortho tech at the ER opened the cast window more and could visualize a 2 cm. by 1 cm. area of erythema consistent with a new pressure ulcer. ER instructed the family, who arrived with the resident that the resident needed to keep his/her leg elevated. The family stated they tried to elevate the leg but the facility left the leg in the dependent position up to 8 hours at a time. The ER document identified the decubitus developed secondary to pressure at the cast site due to the leg hanging in the dependent position. On 12/19/16 at 11:40 a.m. Staff FF LPN stated she worked with the resident on the first day the resident was at the facility with a cast. She stated the resident did not have a leg extender on the wheelchair and the resident's leg hung in the dependent position and no one did anything about it so she got a leg extender and pillow so she could elevate the leg. On 12/20/16 at 1 p.m. during phone exit the Administrator identified Staff FF as a disgruntled employee with credibility concerns. On 11/23/16 at 1:24 p.m. the orthopedic ARNP stated there was no new injury to the RLE when the RLE was recasted on 6/23/16. The ARNP stated there was nothing the ortho office saw regarding the facility care of RLE that caused concerns. There was a lot of he said/she said. The ortho recasted the leg on 6/23/16 at the family request. Nursing progress notes dated 6/29/16 at 9:52 a.m. staff documented the heel ulcers identified on 6/21/16 as improved. The small superior wound measured 0.6 cm. by 0.3 cm. with fibrin in the wound bed. The distal DTI measured 2 cm. The entry identified an ill-fitting cast with			

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	a large gap between the plantar aspect of the foot and the cast. Staff visualized purple skin to the skin at the right lateral malleolus at the cast edge measuring 2.3 cm. by 0.5 cm. A gray/purple wound at the achilles measured 1 cm. by 2.5 cm. Nurses notes dated 7/1/16 at 1:45 p.m. identified a new full cast in place and pressure wounds covered by the new cast. On 11/28/16 at 4:05 p.m. the Director of Nursing (DON) stated they facility was unable to assess the areas after 6/29/16 due to placement of long cast. A wound center note identified the resident went to the center 7/13/16. A 4 cm. by 2 cm. by 0.1 cm. unstageable pressure ulcer was present on the right posterior heel. A 2 cm. by 1.5 cm. by 0.1 cm. stage 2 pressure ulcer was present on the dorsal aspect of the foot. The wound center directed staff to apply Betadine and foam dressing daily after the resident got his/her brace fit. Review of the treatment administration record (TAR) identified the facility began the Betadine treatment on 7/17/16. Nursing progress notes dated 7/15/16 at 10:45 a.m. revealed the resident returned with a brace at that time. On the same date at 2:18 p.m. staff attempted to measure the resident's skin impairments of the RLE. The resident did not cooperate so staff could not measure but just estimated sizes as follows: 1. There was a deep purple color to the right medial heel approximately 5 cm. by 3.5 cm. There was no open skin within the area. 2. There was a wound to the plantar aspect of the right heel approximately 4 cm. by 2 cm. The wound bed had black necrotic tissue. The periwound skin was dry with			

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	desquamation. 3. There was an approximate 3 cm. by 3 cm,. nonblanching red wound to the anterior foot. 4. There was an approximate 2.5 cm. by 2.5 cm. wound to the medical aspect of the right heel. There was no skin impairment to the coccyx. The record lacked evidence of any further skin assessments. The resident discharged to the hospital on 7/29/16. The TAR identified the facility signed for the Betadine treatment to the RLE 8 out of 14 days. **FACILITY RESPONSE:**			

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