STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165156	A. BUILDING _____ B. WING _____	R-C 01/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORT DODGE HEALTH AND REHABILITATION	728 14TH AVENUE NORTH FORT DODGE, IA 50501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Correction date 2/14/2017 The following deficiencies were a result of the facility re-visit to 64508-M and investigation of complaint #65580-C (See code of federal regulations (42CFR) Part 483, Subpart B-C)	{F 000}	This plan of correction constitutes my written credible allegation of compliance. Correction date 02/14/17 for all Tags listed. The response or providers plan of correction contained herein shall not be considered to be or construed as an admission of the validity of the citation or alleged deficiency to which it is addressed.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 279	Please see page 2-3 for POC.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debra K Koenig

TITLE: Executive Director/LNHA

(X6) DATE: 02/15/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and resident interview the facility failed to develope a comprehensive care plan which included interventions to prevent the development of pressure sores for one of one residents reviewed with multiple pressure sores. The resident had	F 279	F279 Fort Dodge Health and Rehabilitation will develop a comprehensive care plan which will include interventions to prevent the development of pressure sores for # 8 and all other at risk for pressure sore residents. The MDS RN has been educated to implement the recommended interventions per the Braden Risk Assessment for each level identified per the assessment score.	02/14/2017

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F 279	Continued From page 2 been determined to be at risk of developing pressure sores on admission. (Resident #8) The facility census was 53. Findings include: The Minimum Data Set (MDS) assessment for Resident #8 dated 1/4/17, documented an admission date of 12/22/16, and included diagnoses of fracture other than hip, muscle weakness, difficulty walking, embolism and thrombosis unspecified deep veins of right distal lower extremities. The MDS documented the resident required extensive assistance of two for bed mobility and transfer, with a risk of developing pressure ulcers, no unhealed pressure ulcers and no repositioning program. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). A hospital discharge order dated 12/22/16, included a directive for a knee immobilizer and care instructions for a broken lower leg. A Braden Scale for Predicting Pressure Sore Risk dated 12/22/16 at 3:30 p.m., documented the resident scored a 10 for high risk of pressure sores. The form documented the resident had a displaced bicondylar fracture of the left tibia, subsequent encounter for closed fracture. The form documented the resident had slightly limited sensory perception, constantly moist skin, chairfast with very limited mobility, poor nutrition and a friction and shear problem. The care plan dated 12/22/16, included no problem of a risk for altered skin integrity or pressure sore.	F 279	The Interdisciplinary Team will review new admissions as well as change of conditions Monday -Friday at daily stand-up to ensure appropriate preventive measures have been added to the plan of care. This will continue on an ongoing basis. The Director of Nursing and or designee will Continue to monitor skins monthly through the facility Quality Assurance Program and assess the need for new systems on a monthly process. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	

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F 279	Continued From page 3 A skin alteration incident sheet dated 1/12/17 at 11:16 a.m., documented the therapy assistant called the nurse into the room to look at an area to lower left leg. Nurse observed area to posterior calf, red wound bed, no signs or symptoms of infection, area 2.0 centimeters (cm) x 2.0 cm top area and 1.0 cm x 0.5 to lower area. The form documented the predisposing factors had been resident wore brace and unable to bend leg, foot pedal had to be up at all times. A skin alteration incident sheet dated 1/12/17 at 9:30 p.m., documented the nurse had been summoned to resident room by Certified Nurse Aide to assess two blisters, one on each heel. Complained of heels burning. Fax out to primary care provider to update and receive treatment order, both heels floated at all times as of now. The form included no measurements. The second page of the form had been left blank. On 1/14/17, the facility added a problem of pressure ulcers to bilateral heels related to immobility. The problem included the following interventions: a. Call light within reach, initiated 1/14/17. b. Daily body checks, initiated 1/14/17. c. Encourage fluid intake and assist to keep skin hydrated, initiated 1/14/17. d. Float heels at all times, initiated 1/19/17. e. Heel lift boot bilateral lower extremities, to be worn anytime residents heels could be resting on	F 279		

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F 279	Continued From page 4 any kind of surface, initiated 1/26/17. f. Needs moisturizer applied to skin. Do not massage over bony prominences and use mild cleansers for Peri-care/washing, initiated 1/14/17.	F 279		
	g. Protein supplement daily, initiated 1/26/17. h. Requires pressure relieving/reducing device on bed/chair, initiated 1/14/17. i. Treat areas to heel and other skin issues per physician orders, initiated 1/16/17. j. Turn and reposition every two hours, initiated 1/26/17. k. Wound center as ordered, initiated 1/27/17. The facility MDS nurse stated during interview on 1/30/17 at 1:20 p.m., they did not know why the resident did not initially have a problem on the plan of care for potential for pressure sore but did now. The MDS nurse agreed the resident had been at risk of developing a pressure sore on admission due to a fracture which required a leg immobilizer and decreased mobility but did not know why it had not been placed on the care plan. The MDS nurse verified staff removed the immobilizer one time per day and checked the resident skin for breakdown. The MDS nurse stated staff repositioned all residents every two hours but only documented it one time per shift.			
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity -	F 314		

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F 314	Continued From page 5 (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and resident interview the facility failed to implement and follow interventions to prevent the development of pressure sores for one of one resident reviewed who was identified on admission at risk and developed multiple facility acquired pressure ulcers (Resident #8). The facility identified a resident census of 53 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #8 dated 1/4/17, documented an admission date of 12/22/16, and included diagnoses of fracture other than hip, muscle weakness, difficulty walking, embolism and thrombosis unspecified deep veins of right distal lower extremities. The MDS documented the resident required extensive assistance of two for bed mobility and transfer, with a risk of developing pressure ulcers, no unhealed	F 314	F341 On 1/30/17 resident #8 care plan was updated to include risk for skin alterations and pressure ulcer prevention interventions were put in place. By 2/10/17, a Full Skin Sweep of current residents was completed by licensed nurses to identify any skin breakdown. A Braden Scale for Predicting Pressure Sore risk was completed by licensed nurses for current residents by 2/3/17 to identify residents who are at high risk. The Care Plan Coordinator updated residents care plans as needed for ulcer prevention, for those residents who were identified at high risk for pressure ulcer, to ensure implementation of interventions to prevent the development of pressure sores for resident #8 and other like residents of the facility. On 2/6/17 the Director of Nursing initiated in-service education to nursing staff related to pressure ulcer prevention, completed by 2/14/17. The Director of Nursing or designee will monitor progress of altered skin conditions weekly to assure continued improvement. The Director of Nursing or designee will monitor on an ongoing basis that Braden Scales are completed on admission and preventative pressure ulcer interventions are in place and care planned for resident who are at high risk. The Director of Nursing or designee will randomly monitor via walking rounds at least 5 days weekly that ulcer prevention approaches are in place and practiced consistently. The Director of Nursing and or designee will report findings of above monitoring system(s) monthly times three months through the facility Quality Assurance Program, then review/assess for need to continue. The plan will be reviewed and revised as indicated and staff will be re-educated as needed.	

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F 314	Continued From page 6 pressure ulcers and no repositioning program. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). A physician transfer order report dated 12/22/16, included a directive for a knee immobilizer and care instructions for a broken lower leg. A Braden Scale for Predicting Pressure Sore Risk dated 12/22/16 at 3:30 p.m., documented the resident scored a 10 for high risk of pressure sores. The form documented the resident had a displaced bicondylar fracture of the left tibia, subsequent encounter for closed fracture. The form documented the resident had slightly limited sensory perception, constantly moist skin, chairfast with very limited mobility, poor nutrition and a friction and shear problem. The care plan dated 12/22/16, included no problem of a risk for altered skin integrity or pressure sore. Review of a Treatment Administration Record for January 2017, revealed a directive to remove (leg immobilizer) once a day for skin checks and cleaning then re-apply. A skin alteration incident sheet dated 1/12/17 at 11:16 a.m., documented the therapy assistant called the nurse into the room to look at an area to lower left leg. Nurse observed area to posterior calf, red wound bed, no signs or symptoms of infection, area 2.0 centimeters (cm) x 2.0 cm top area and 1.0 cm x 0.5 to lower area. The form documented the predisposing factors had been resident wore brace and unable to bend leg, foot pedal had to be up at all times.	F 314		

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F 314	Continued From page 7 A physician fax form dated 1/12/17, reported the resident had an area to posterior calf 2.0 cm x 2.0 cm and 1.0 cm x 0.5 cm.. A skin alteration incident sheet dated 1/12/17 at 9:30 p.m., documented the nurse had been summoned to resident room by Certified Nurse Aide to assess two blisters, one on each heel. Complained of heels burning. Fax out to primary care provider to update and receive treatment order, both heels floated at all times as of now. The form included no measurements. The second page of the form had been left blank. A physician fax form dated 1/13/17, reported a 2.0 cm x 1.0 cm fluid filled blister on each lateral heel, skin intact, would like to apply skin prep two times daily until resolved and will float heels.. On 1/14/17, the facility added a problem of pressure ulcers to bilateral heels related to immobility. The problem included the following interventions: a. Call light within reach, initiated 1/14/17. b. Daily body checks, initiated 1/14/17. c. Encourage fluid intake and assist to keep skin hydrated, initiated 1/14/17. d. Float heels at all times, initiated 1/19/17. e. Heel lift boot bilateral lower extremities, to be worn anytime resident's heels could be resting on any kind of surface, initiated 1/26/17. f. Needs moisturizer applied to skin. Do not massage over bony prominences and use mild cleansers for Peri-care/washing, initiated 1/14/17. g. Protein supplement daily, initiated 1/26/17. h. Requires pressure relieving/reducing device on bed/chair, initiated 1/14/17. i. Treat areas to heel and other skin issues per	F 314		

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F 314	Continued From page 8 physician orders, initiated 1/16/17. j. Turn and reposition every two hours, initiated 1/26/17. k. Wound center as ordered, initiated 1/27/17. A wound nurse recommendation sheet dated 1/24/17, documented the resident had been seen for initial assessment of wound. Resident has wound to each heel-right lateral heel measures 2.0 cm x 2.0 cm and left lateral heel measures 1.5 cm x 1.5 cm. Both wound areas are light purple intact but non blanchable. Resident also has wound to left posterior lower leg. This is an unstageable pressure wound measuring 6.8 cm x 2.5 cm x 0.5 cm. The sheet included a directive for no pressure to heels and had been noted 1/25/17. A wound healing center report for 1/26/17, documented the resident had a wound on the left lateral lower posterior leg (wounding event not known) , left lateral calcaneus (gradually appeared), and right lateral calcaneus (gradually appeared). The report documented the primary etiology of all three wounds had been pressure ulcer. The report documented the measurements as follows: a. left lateral posterior lower leg, open-6.0 cm x 2.4 cm x 0.2 cm b. left lateral calcaneus, open-1.4 cm x 1.5 cm x 0.1 cm c. right lateral calcaneus, open-2.0 cm x 2.0 cm x 0.1 cm The form documented the left lateral posterior lower leg ulcer to be a Stage 3, and the left and right lateral calcaneus ulcers to be unsteageable. The report documented all three of the pressure ulcers had a large amount of necrotic (dead)	F 314		

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F 314	Continued From page 9 tissue (67-100%). The form documented the resident required debridiment (removal of damaged tissue) of the left lower leg wound with a topical anesthetic applied to ease pain. A wound healing discharge instruction sheet dated 1/26/17, included the following directives: a. Wound #1 left lateral posterior lower leg-cleanse with normal saline, apply Calcium Alginate (anti-microbial wound dressing) with silver to wound bed, cover with foam dressing and secure. b. Wound #2 left lateral calcaneus-cleanse with normal saline, betadine daily, cover with foam dressing and secure, heel lift boot anytime heels could be resting on any kind of surface. Turn and reposition every two hours. c. Wound #3 right lateral calcaneus-cover wound with foam dressing, secure in place, heel lift boot anytime heels could be resting on any kind of surface. Turn and reposition every two hours. Clinical record revealed an order to discontinue brace to left leg dated 1/26/17. A physician order summary report for the month of January 2017, included a directive for heel suspension boots to bilateral lower extremities anytime the resident's heels could be resting on any kind of surface, with a start date of 1/26/17. The facility MDS nurse stated during interview on 1/30/17 at 1:20 p.m., they did not know why the resident did not initially have a problem on the plan of care for potential for pressure sore but did now. The MDS nurse agreed the resident had been at risk of developing a pressure sore on	F 314		

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F 314	Continued From page 10 admission due to a fracture which required a leg immobilizer and decreased mobility but did not know why it had not been placed on the care plan. The MDS nurse verified staff removed the immobilizer one time per day and checked the resident skin for breakdown. The MDS nurse stated staff repositioned all residents every two hours but only documented it one time per shift. At 1:52 p.m., the resident sat in a recliner with their feet elevated on two pillows and the bilateral heels resting on the pillows. The resident wore socks and no heel boots. The resident stated they did not feel the facility had been taking good care of their wounds because they had just used the call button to have staff come in and put pillows under their feet because their heels had been on the chair and it hurt. The resident stated the wound on their leg had been from a brace that had sometimes felt too tight. At 4:00 p.m., the surveyor asked the facility MDS nurse what could have been done to prevent the pressure sores. The MDS nurse stated off loading the residents heels. On 1/31/17 at 7:30 a.m., the facility Administrator stated they believed the open areas had not been pressure sores but were venous. The Administrator stated the resident always had their heels elevated. The Administrator stated they did not know if the facility had acquired heel lift boots for the resident, and stated this morning had implemented a Braden scale check list for staff to use on all residents to ensure appropriate interventions were placed and followed for residents. The Administrator stated the wound nurse classified everything as a pressure sore even if it had not been and they had told the	F 314		

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F 314	Continued From page 11 wound nurse to stop doing that. At 7:40 a.m., the surveyor asked the Administrator to accompany them to the facility dining room to show the surveyor where the resident sat. The resident sat in a wheel chair with their bilateral feet on the wheel chair pedals. The pedals were not elevated. The left foot rested directly on the center of the pedal, the right leg slightly extended with the right heel directly on the pedal. The surveyor pointed this out to the Administrator who then stated the resident had foam dressings on the heel ulcers. The Administrator then went to the resident's room and found two foam boots and placed them on the residents bilateral feet. Staff A (Certified Nurse Aide, CNA) at 7:51 a.m., approached the surveyor and stated they had made sure the residents heels were floated when they had transferred the resident into the wheel chair that morning. Staff A stated the resident would not put heel boots on for them but had done so for the Administrator. Staff A stated one day they were not floating the resident's heels and the next day they were. Staff A stated they did not know when the intervention to float the resident's heels started. The wound clinic nurse stated during interview at 8:00 a.m., the areas on the residents leg and heels were definitely pressure sores, even though the residents circulation had been compromised the wounds developed from pressure to the areas. The wound nurse stated the leg immobilizer should have been checked every shift to be sure it had not been compromising circulation more or rubbing on the skin. The wound nurse stated the facility would not have	F 314		

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FORT DODGE HEALTH AND REHABILITATION	728 14TH AVENUE NORTH FORT DODGE, IA 50501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 needed to wait for the wound clinic to call the orthopedic surgeon to get the immobilizer discontinued and could have done this after the open areas had been discovered. At 8:45 a.m., the resident sat in a recliner as Staff B (Registered Nurse, RN) completed a treatment to the bilateral heels. Staff B measured a dark purple are to the left lateral heel to be 1.5 cm x 2.0 cm. Staff B measured a dark purple are to the right lateral heel to be 2.0 cm x 2.5 cm. Staff B applied Mepilex foam dressings to both heels at which time the facility Director of Nursing commented the dressings cost 5 dollars each. Upon completion of the treatment the facility Director of Nursing stated the facility would be having a different wound clinic nurse see the resident and complete the treatment to the left lower leg.	F 314		