| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| MANORCARE HEALTH SERVICES -WEST DES MOINES | 5010 GRAND RIDGE DRIVE WEST DES MOINES, IA 50265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>Correction Date 2/28/2018 ? 3/10/2018<br><br>The following information deficiencies relate to the investigation of facility self-reported incidents 72507-I, 72883-I, and 73675-I and complaints 70871-C, 71499-C, 71970-C, 72247-C, 72253-C, 72406-C, 72512-C, 72569-C, 72571-C, 72788-C, 73145-C, 73206-C, and 73088-C.<br><br>All of the complaints and facility reported incidents 72883-I and 73675-I were substantiated.<br><br>Facility reported incident 72507-I was not substantiated.<br><br>See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C. | F 000 | Please See Attached Providers POC.<br><br>HEALTH FACILITIES<br>MAR 12 2018 | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and resident, family member and staff interviews, the facility failed to provide care that maintained each resident's dignity with reasonable accommodation of the resident's needs for 2 of 20 residents reviewed (Residents #2 and #10). The facility reported a census of 79 residents. | F 558 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] | Administrator | 3/8/2018

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.

POC accepted 3/14/18 jmeehan.cw

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1. The Minimum Data Set (MDS) Assessment tool dated 12/22/17 revealed Resident #2 had diagnoses that included quadriplegia (paralysis below the neck), depression, colostomy and urostomy alterations, displayed intact cognition with no symptoms of delirium, required extensive assistance by at least 1 staff for reposition in bed, eating, toileting and personal hygiene, and extensive assistance by 2 or more staff for dressing, transfers to and from bed and chair and bathing.

An Activity of Daily Living (ADL) self-care deficit problem on the nursing care plan directed staff to assist with daily hygiene, grooming, dressing, oral care and eating, and to assist the resident to reposition.

A potential for skin breakdown problem related to ileostomy on the nursing care plan directed staff to change the ostomy appliance as needed, and report changes in bowel movement frequency, consistency or control.

During an interview on 1/16/18 at 4:01 p.m., the resident stated her colostomy bag often filled with air, staff required to check the status and empty the air every couple hours but they don't, the colostomy bag bursts, the fecal contents spreads over her body and bedding, has got into her hair, has came in contact with her face when staff removed her soiled shirt, quite an embarrassment and avoidable if staff provided her care as directed.

During the same interview, the resident stated one day around 11 a.m., Staff X, certified nursing assistant (CNA), removed her night gown, left her in bed exposed, with the privacy curtain pulled

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half way and the door left open. The resident's family member walked into the room and found the resident exposed and called for staff assistance, the resident said she didn't want to be left exposed like that.

During an interview on 1/16/18 at 4:18 p.m., Staff B, licensed practical nurse (LPN), stated the night shift left the resident in a soiled bed this morning, her colostomy bag had leaked, and she had to direct the other nursing staff to check on the aides to make sure they performed their assigned cares.

During an interview on 1/8/18 at 6:30 p.m., the resident's family member stated he/she arrived at the facility around 11 a.m. on 1/3/18, the resident laid in the bed naked with the door open, privacy curtain pulled about half way between the 2 resident beds, she used the call light to summons assistance, Staff Y, CNA responded and told him/her staff had an emergency and had to leave the resident's room.

During an interview on 1/17/18 at 1:55 p.m., Staff Y stated on the day in question, she returned from break around 11 a.m., the resident's call light was on, a family member stood in the opened doorway as she answered the light, the privacy curtain pulled most of the way between the 2 beds, the resident's pants pulled up to her knees, could not recall whether or not the resident had a shirt on and the resident not covered with a sheet.

2. The Minimum Data Set (MDS) Assessment tool dated 10/9/17 revealed Resident #10 had diagnoses that included seizure disorder and intracranial injury, had severe cognitive

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impairment, and required extensive assistance by 2 or more staff members for transfers to and from bed and chair, bathing, dressing, toileting and personal hygiene, received all nutrition and hydration via enteral feeding tube, and always incontinent of bowel and bladder.

During an interview on 12/13/17 at 2:30 p.m., the resident'sfamily e mber and alternate responsible party stated he/she found the resident in a urine soaked bed around 9 p.m. on 12/9/17, a certified nursing assistant (CNA) that helped her with the required care said she was the only aide on the hall that night. The family member stated he/she returned the following day between 8 a.m. and 9 a.m., found the resident in the same position he/she had left them in, again in a urine soaked bed, provided incontinence care as he/she couldn't locate staff for assistance, marked the incontinence brief applied to the resident, returned later at 9 p.m. and found the resident again in a urine soaked bed with the same marked brief on and performed the required care again, unassisted by staff. The family member stated he/she would preferred that staff at the facility provided care the resident needed, but he/she had no choice.

During an interview on 12/13/17, the former DON stated she had no reason not to believe the resident's family member, if he/she said they performed the only incontinence care the resident received at the time then that was correct.

During an interview on 12/18/17 at 12:50 p.m. , Staff E, RN and former unit manager, stated she knew the resident's family member and if they said they provided the only care the resident had, that was true, the family member was frequently

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| F 558 | Continued From page 4<br>at the facility and marked the resident's incontinence briefs before when he/she suspected the care was not performed and it was true then as well. | F 558 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or | F 580 | | |

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| F 580 | Continued From page 5<br>State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and family and staff interviews, the facility failed to notify a resident's responsible party of a change in resident condition for one of 10 residents reviewed (Resident #16). The facility reported a census of 79 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) Assessment tool dated 8/16/17 revealed Resident #16 had diagnoses that included aphasia (difficulty with speech), hemiplegia (paralysis of 1 side of the body), and severe cognitive impairment. The MDS documented the resident required assist of at least 2 staff for transfers, bathing, dressing, toilet use and personal hygiene.<br><br>An activity of daily living (ADL) self-care deficit problem on the nursing care plan directed 2 staff to assist the resident with dressing, transfers and | F 580 | | |

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| F 580 | Continued From page 6<br>bathing.<br><br>An Incident Report, created on 11/1/17 at 2:27 p.m., documented staff found the resident on the floor on 10/30/17 at 6:15 p.m. by her bed and with the sheet under her. The incident report revealed the resident was incontinent of urine and without major injury. Staff documented the resident was crying, but they were unable to ascertain whether it was from pain or some other reason, and they assisted the resident to bed. The form revealed staff notified the physician of the fall on 11/1/17 at 12:00 p.m., and the responsible party on 11/1/17 at 12:00 p.m.<br><br>During an interview on 12/4/17 at 9:41 a.m., the resident's responsible party stated they visited the resident several times a week, but not notified of the fall until 11/3/17, when they visited while the Hospice aide was present. The responsible party stated the aide noticed something abnormal with the resident's eye; they questioned nursing staff about it and were informed at that time the resident fell on 10/30/17. The responsible party reported when she asked the DON why they weren't notified of the fall, the DON stated the facility had notified Hospice.<br><br>During an interview on 1/23/18 at 2:25 p.m., the executive director of the resident's Hospice program stated their Hospice aide contacted the Hospice nurse on 11/1/17 and informed them of the 10/30/17 fall, not the facility. | F 580 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, | F 584 | | |

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| F 584 | Continued From page 7<br>comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by: | F 584 | | |

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| F 584 | Continued From page 8 | F 584 | | |

Based on observation, record review, and staff interviews, the facility failed to maintain a safe, clean and sanitary environment. The facility reported a census of 79 residents.

Findings include:

The Minimum Data Set (MDS) Assessment tool dated 12/27/17 revealed Resident #12 had diagnoses that included arthritis and anxiety and displayed intact cognition. The MDS documented the resident required limited assistance of 1 staff for transfers, ambulation (walking), dressing, bathing, toilet use and personal hygiene.

Observation in room #120 on 1/4/18 at 11:15 a.m. revealed the wallpaper located between the heating/air-conditioning unit and the window above it peeled away from the wall, and the wall paper on both sides of the area also peeled away from the wall. The exposed wall revealed multiple irregularly shaped, brown and black areas that varied in size from 1 centimeter (cm), to more than 10 cm. The stains on the wall paper surface were in contact with the same stains on the wall. Observation at the same time in room #123 and #116 revealed a rectangular shaped wall paper replacement, above the heating/air-conditioning unit and below the window, the width of the window.

During an interview on 1/4/18 at 11:15 a.m., Resident #12 stated the maintenance person had done work by the window, there was mold there and mold made people sick. The resident did not know what work would be done in his room or when it would be completed, and was upset the spots were located by the heating and air-conditioning unit and the wall paper was left

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| F 584 | Continued From page 9<br>peeled from the wall.<br><br>During an interview on 1/4/18 at 11:40 a.m., Staff Z, maintenance director, stated the spots on the wall beneath the wall paper was a common problem that resulted from moisture in contact with the adhesive, and he had made successful repairs of the same problem in other rooms.<br><br>During an interview on 1/4/18 at 12:45 p.m., Staff Z stated he was not able to provide documentation on the wall paper adhesive problem or authorized repair. He reported he had consulted with a company and he could continue to repair the areas around the windows in each room as long as the area was less than 10 square feet, and the residents were removed from the rooms when the work was completed.<br><br>During an interview on 1/4/18 at 1:10 p.m., the administrator stated he would provide a written remediation plan for the rooms that required removal of black colored spots on the walls.<br><br>A contract proposal, dated 1/5/18, revealed work contracted on 33 resident rooms on the facility's lower level included repair of the exterior walls, cleaning of walls with bleach solvent as deterrent for a moisture issue. The proposal also included Kiltz coat applied to walls, and the walls refinished, primed, painted, new rubber base applied, and caulk applied to exterior of windows and walls as needed. | F 584 | | |
| F 604 SS=D | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect | F 604 | | |

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| F 604 | Continued From page 10<br>and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and resident, family and staff member interviews, the facility failed to ensure each resident remained free from physical restraint imposed for convenience and not required to treat the resident's medical symptoms for 1 of 19 resident records reviewed (Resident #9). The facility reported a census of 79 residents. | F 604 | | |

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| F 604 | Continued From page 11<br>Findings include:<br><br>The Minimum Data Set (MDS) Assessment tool dated 9/18/17 revealed Resident #9 had diagnoses that included Alzheimer's disease, dementia, anxiety, depression and psychotic disorder, had severe cognitive impairment with symptoms of delirium, and required extensive assistance of 2 staff for transfers to and from bed and chair, bathing, dressing, toilet use and personal hygiene.<br><br>A communication care plan listed on the nursing care plan revealed the resident spoke only another language (not English), and directed staff to utilize interpreters that included family members, and use gestures and simple sentences while maintaining eye contact.<br><br>An activity of daily living (ADL) self-care deficit care plan directed staff to transfer the resident with a mechanical lift.<br><br>A physical agitation/aggression care plan directed staff to approach the resident slowly with a happy demeanor, leave resident if strategies not working and re-approach later. The care plan also directed staff to speak in a low pitch and calm voice and use consistent routines and caregivers.<br><br>Documents included in the facility's self-reported incident stated Staff AA, certified nursing assistant (CNA), reported another CNA, Staff G, restrained Resident #9's arm under her gown during a mechanical lift transfer.<br><br>The facility's Abuse, Neglect, Exploitation, Mistreatment & Misappropriation Prevention policy, dated 11/2016, directed: | F 604 | | |

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| MANORCARE HEALTH SERVICES -WEST DES MOINES | 5010 GRAND RIDGE DRIVE WEST DES MOINES, IA 50265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 604 | Continued From page 12<br><br>1. The facility must ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.<br>2. Abuse defined as a willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.<br><br>When reviewed on 12/13/17, Staff G's personnel file revealed hired on 2/2/10, a certificate for completion of the mandatory 2 hour dependent adult abuse education, dated 9/22/09, and no other documentation of dependent adult abuse education as required (2 hours of mandatory reporter of dependent adult abuse education every 5 years).<br><br>Staff interviews revealed:<br><br>12/18/17 at 5:54 p.m., Staff AA stated she worked on 12/5/17 from 2 p.m. to 10 p.m. with Staff G, as they transferred the resident from wheel chair to bed, the resident grabbed a part of the mechanical lift with her right hand. Her grip wasn't strong and this employee could redirect the resident, but Staff G grabbed the lower portion of her gown, tied it behind the resident's neck which contained the resident's arms in the process, and Staff G said "she wasn't going to to put up with this shit". Staff AA stated she untied it, completed the resident's transfer and reported it to the administrator right afterward.<br><br>1/4/18 at 11:59 a.m., Staff G stated the resident grabbed the bar on the mechanical lift and could have became injured during the transfer, they had | F 604 | | |

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| F 604 | Continued From page 13<br>the resident hold items in the past but that didn't work. On 12/5/17, she transferred the resident with Staff AA, she operated the lift controls and Staff AA should have guided the resident in the sling and redirected the resident's hand movement but she did not, this employee tucked the bottom of the gown behind the resident's shoulders (while suspended in the sling), the resident could still move her arm under the gown but wouldn't have been able to grab at things or hurt her hand that way, thought she had protected the resident during the transfer and didn't think the action was considered a restraint.<br><br>12/18/17 at 2:05 p.m., the administrator stated he was in the building on the evening of 12/5/17, Staff AA reported the incident to him, Staff G was sent home and remained suspended at that time, he notified the DON who was also still in the building, and they initiated their investigation of the incident.<br><br>1/18/18 at 5:45 p.m., registered nurse (RN) and former unit manager stated she was in the building when the incident occurred on 12/5/17 and notified by the administrator. She completed a physical assessment of the resident at that time and there were no signs of injury. | F 604 | | |
| F 607 SS=D | Develop/Implement Abuse/Neglect Policies<br>CFR(s): 483.12(b)(1)-(3)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, | F 607 | | |

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| F 607 | Continued From page 14<br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete the required criminal background checks and obtain the appropriate authorizations for the employees to work prior to the date of hire for 3 of 8 employee personnel records reviewed. The facility reported a census of 79 residents.<br><br>Findings include:<br><br>Review of employee personnel files revealed:<br><br>1. A SING (Single Contact & Licensing Background Check) check performed 7/19/17 revealed further search required prior to hire of Staff F, chauffeur, and on 7/24/17, the record was cleared for employment. Staff F was hired by the facility on 7/17/17.<br><br>2. A SING check performed 2/27/17 revealed further search required prior to hire of Staff H, certified nursing assistant (CNA). Information from the Iowa Department of Criminal Investigation received on 3/1/17 revealed Staff H arrested on 11/25/16, and without disposition as of that date. A request for authorization from the Iowa Department of Human Services on 3/7/17, to clear Staff H's criminal history for work at the facility, revealed the department couldn't authorize the action because the 11/25/16 arrest was without disposition. The facility did not make another attempt to obtain authorization for Staff | F 607 | | |

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| F 607 | Continued From page 15<br>H's employment prior to the review conducted 1/17/18. Staff H worked at the facility from her 3/18/17 hire date until 1/9/18 when placed on suspension.<br><br>3. Staff G, CNA, hired 2/2/10, received the required 2 hours of dependent adult abuse education on 9/22/09. When the record was reviewed on 12/13/17, there was no other documentation of the education required, at a minimum, of every 5 years. The facility provided documentation that the required abuse education was completed 1/9/18.<br><br>The facility's Criminal History Check policy, dated 1/14/13, directed:<br>1. Criminal background checks will be conducted within the guidelines of specific state and federal laws, and job offers are made contingent upon successful completion of criminal background checks and other pre-employment checks and policies.<br>2. The human resources director must review any situation where an applicant or employee is found to have a criminal history.<br>3. The human resources designee must obtain information regarding the facts of the crime and provide that information to the area human resources director.<br>4. All applicable state, federal and local laws must be followed for applicants with a criminal history.<br><br>During an interview on 1/24/18 at 9:50 a.m., the facility's interim administrator stated there had been a change of personnel in the HR department, and Staff H terminated due to additional arrests since her date of hire that she did not report to the facility as required. | F 607 | | |

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| F 620 | Continued From page 16 | F 620 | | |
| F 620 SS=D | Admissions Policy<br>CFR(s): 483.15(a)(1)-(7)<br><br>§483.15(a) Admissions policy.<br>§483.15(a)(1) The facility must establish and implement an admissions policy.<br><br>§483.15(a)(2) The facility must-<br>(i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and<br>(ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.<br>(iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property.<br><br>§483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.<br><br>§483.15(a)(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other | F 620 | | |

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| F 620 | Continued From page 17 | F 620 | | |

consideration as a precondition of admission, expedited admission or continued stay in the facility. However,-
(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and
(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

§483.15(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

§483.15(a)(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.

§483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must

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| F 620 | Continued From page 18 | F 620 | | |

specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review, and staff and responsible party interviews, the facility failed to obtain authorization for admission and treatment, and failed to provide documentation that showed a resident's responsible party received all mandatory written notifications related to the admission for 2 of 20 resident records reviewed (Resident #16 and #18). The facility reported a census of 79 residents.

Findings include:

1. The Minimum Data Set (MDS) Assessment tool dated 8/4/17 revealed Resident #16 admitted to the facility on 7/28/17 with diagnoses that included arthritis, acute pain, muscle weakness, and history of falls. The MDS documented the resident as independent for daily decision making and cognitive skills, required extensive assistance of at least 1 staff for transfers, ambulation (walking), bathing, dressing, toilet use and personal hygiene. The MDS revealed the resident discharged from the facility on 8/22/17.

When a copy of the signed admission agreement for the resident's 7/28/17 admission was requested, the facility provided a copy of a confirmation of delivery receipt, addressed to a family member identified as the #2 emergency contact on facility documents, delivered on 10/5/1, and stated they attempted to obtain the required signatures and authorization for the resident's care but were unsuccessful. The facility did not have documentation that showed

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| F 620 | Continued From page 19<br>the resident had a responsible party other than the resident.<br><br>2. The Minimum Data Set (MDS) Assessment tool dated 12/7/17 revealed Resident #18 admitted to the facility on 12/2/17 with diagnoses that included conduct disorder, intellectual disabilities, and fracture, severe cognitive impairment. The MDS documented Resident #18 required limited assist of 1 staff for transfers and toilet use and extensive assistance of 1 or 2 staff for dressing, bathing and personal hygiene.<br><br>Record review revealed the resident discharged on 12/7/17.<br><br>The facility could not provide a signed admission agreement and did not have the required documentation related to the resident's legal guardian and decision maker. | F 620 | | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in | F 623 | | |

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| F 623 | Continued From page 20<br>paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal | F 623 | | |

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| F 623 | Continued From page 21<br>hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). | F 623 | | |

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| F 623 | Continued From page 22<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and staff and family member interviews, the facility failed to provide the required 48 hour notice of their decision to discharge a resident from skilled therapy services, failed to address the resident's special needs, and failed to involve the resident's responsible party in an appropriate discharge plan. The facility reported a census of 79 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) Assessment tool dated 12/7/17 revealed Resident #18 admitted to the facility on 12/2/17 with diagnoses that included Down's syndrome, conduct disorder, intellectual disabilities and fracture. The MDS documented the resident experienced severe cognitive impairment and required limited assist of 1 staff for transfers, and toilet use, extensive assistance of 1-2 staff for dressing, bathing and personal hygiene. The MDS also documented the resident had a deficit of 1 lower extremity, was rarely able to understand others or make self understood, and displayed verbal behaviors directed toward others that occurred 1 to 3 days of the 7 days of the assessment period.<br><br>A Preadmission Screening and Resident Revue (PASRR) assessment completed 11/30/17 revealed an exempted hospital discharge granted for nursing facility care, Level II criteria met due to the resident's intellectual disabilities and was required if more than 30 days of care required at the facility. The PASRR revealed the resident had not had recent symptoms of mental illness or recent inpatient psychiatric hospitalizations, | F 623 | | |

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| F 623 | Continued From page 23 | F 623 | | |

experienced moderate to severe cognitive skills for daily decision making and required extensive assistance with dressing, hygiene and mobility. The document directed the facility to submit a status change to Ascend for an immediate evaluation if any signs or symptoms of psychiatric instability developed.

Physician orders directed:

1. Brace locked in full extension on the left lower extremity at all times, with non weight bearing status of the left leg.
2. Vicodin 5/325 milligrams (a strong narcotic analgesic), 1 tablet administered every 4 hours as needed.
3. Oxycodone IR (immediate release, a strong narcotic analgesic) 5 milligrams administered oral every 4 hours as needed.
4. Tylenol with Codeine (a narcotic analgesic) 300-30 milligrams, 1 tablet every 6 hours as needed.
5. Tylenol 650 milligrams oral every 4 hours as needed.
6. On 12/6/17, Vicodin 5/325 milligrams 1 tablet oral 4 times per day.
7. On 12/6/17, may discharge from facility. The order was requested by the DON.

Medication administration records revealed the resident received analgesics as follows:

a. 12/2/17 - Tylenol at 8:05 p.m., Vicodin at 11:50 p.m.
b. 12/3/17 - Oxycodone at 4:51 a.m. and 9:15 a.m., Vicodin at 9:06 p.m.
c. 12/4/17 - Tylenol at 1:48 a.m., Vicodin at 1:20 p.m.
d. 12/5/7 - Vicodin at 11:51 a.m., 4:30 p.m. and

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| F 623 | Continued From page 24<br>11:15 p.m.<br><br>A physician progress note dated 12/5/17 revealed the resident was admitted to the facility due to debility from a fractured left leg, intellectual disability, and conduct disorder. An assessment had been required that day for acute pain management, with pain rated at 4 on a 0 to 10 pain scale. The note documented the resident as unable to communicate when pain control needed, and the physician ordered staff to administer analgesics on a scheduled basis. The note also documented skilled therapies provided at the facility with goal to return home, but the resident would likely be a candidate for an intermediate care facility (ICF) level of care.<br><br>A physical therapy evaluation completed 12/4/17 revealed the resident required physical therapy to increase independence with gait and functional mobility, increase functional activity tolerance, lower extremity range of motion and strength. Risk factors included physical impairments and associated functional deficits, risk for falls, further decline in function, muscle atrophy, increased dependence on caregivers and decreased ability to return to prior living environment.<br><br>An occupational therapy evaluation completed 12/3/17 revealed the resident wore a leg brace with non weight bearing status, required therapy to increase independence with activities of daily living, functional activity tolerance, facilitate sitting tolerance and postural control. Risk factors included further decline in function, falls, muscle atrophy, increased dependency upon care givers, limited out of bed activity, and depression.<br><br>A cognitive loss related to | F 623 | | |

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Intellectual/developmental disability problem on the nursing care plan directed staff to allow adequate time to respond, not to rush or supply words, approach in a calm, positive and reassuring manner, and provide 1 to 1 sessions as indicated.

The nursing care plan addressed pain related to left leg fracture and directed staff to report nonverbal expressions of pain such as moaning, striking out, grimacing, etc., and administer pain medication per physician orders.

Nurse's Notes did not reveal any documentation of resident behaviors.

Interviews with the resident's Guardian revealed:

12/17/17 at 7:03 p.m., the Guardian stated he/she was informed the resident had argued with another resident his first night at the facility 2 days after it happened, he/she could have returned to the facility and addressed the situation had they known, he/she was informed the argument occurred when the other resident spoke to themselves, this resident thought he/she was speaking to him and didn't understand the situation with his cognitive deficits, when this resident responded to the conversation it made matters worse. On 12/5/17, the nursing director told him/her the resident had to leave, he/she had to take him home, the nursing director was rude and told her she had to speak with the administrator. He/she spoke with the administrator and was informed his behaviors weren't appropriate for that nursing home and he had to leave.

1/18/18 at 12:50 p.m., the Guardian stated he/she

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was to pick up the resident after work on 12/6/17, when he/she arrived at the facility the nursing director was waiting for him/her and made them sign a paper in order to remove him from the facility. The Guardian didn't have a copy of it, when he/she got to the resident, he refused to leave until the following morning, and that is when he/she returned to transfer the resident back to his group home.

Staff interviews revealed:

1/24/18 at 11:35 a.m., Staff O, registered nurse (RN) stated the resident was sensitive to noise, had behaviors when 1st admitted but calmed down once moved to a different hall in a quieter area.

12/18/17 at 4:13 p.m., Staff N, certified nursing assistant (CNA) stated one evening the director of nursing (DON) yelled at the resident's family member, he/she was crying and said they didn't want to take the resident home, he/she asked if there wasn't some way he could stay and the DON said no, he's not staying here, he had to go.

12/18/17 at 11:00 a.m., the DON stated she thought the resident had behaviors, he ran into another resident with his wheel chair and yelled at another resident, no injuries resulted, and the administrator spoke with the Guardian about that. The DON could not explain why staff had not submitted a status change to Ascend for an immediate assessment related to the resident's behaviors.

12/18/17 at 11:25 a.m., the interim administrator stated the DON approached him about the resident's behaviors. He reported other residents

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| F 623 | Continued From page 27<br>were upset and he didn't feel the placement was a good fit for the resident, and the DON made the arrangements for the discharge. He also reported he knew the Guardian had other burdens and was very upset about the discharge, and said he was not aware there wasn't documentation about the behaviors and was also not aware they could have requested another assessment from Ascend related to the behaviors. | F 623 | | |
| F 677 SS=E | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and resident, family member, staff and Ombudsman interviews, the facility failed to provide activity of daily living (ADL) assistance and care that included incontinence care, nail care and bathing for 8 of 19 resident records reviewed (Resident's #3, #4, #5, #6, #7, #9, #10 and #11). The facility reported a census of 79 residents.<br><br>Findings include:<br><br>1. The Minimum Data Set (MDS) Assessment tool dated 10/10/17 revealed Resident #3 had diagnoses that included diabetes, cancer, anxiety and depression, scored 12 of 15 points possible on the Brief Interview of Mental Status (BIMS) cognitive assessment and without symptoms of delirium, and required extensive assistance of at least 2 staff for transfers to and from bed and chair, bathing, dressing, toileting and personal | F 677 | | |

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hygiene. A request on 12/12/17 for the resident's shower records for the previous 2 months revealed the facility couldn't provide any documentation of the resident's baths or showers.

2. The Minimum Data Set (MDS) Assessment tool dated 1/15/18 revealed Resident #4 had diagnoses that included multiple sclerosis, scored 15 out of 15 points on the Brief Interview of Mental Status (BIMS) cognitive assessment and without symptoms of delirium, and required extensive assistance of 2 or more staff members for transfers to and from bed and chair, bathing, dressing, toileting and personal hygiene.

A request on 12/12/17 for the resident's shower records for the previous 2 months revealed the resident received showers on 10/14/17, 10/18/17, 11/15/17 and 11/22/17. During an interview on 1/2/18 at 2:55 p.m., the resident stated he currently received showers 2 times a week, but had gone without a shower for over a week, several times, over the last few months.

3. The Minimum Data Set (MDS) Assessment tool dated 11/23/17 revealed Resident #5 had diagnoses that included diabetes, arthritis, and peripheral vascular disease. The MDS documented the resident required extensive assistance of 2 or more staff for transfers, bathing, dressing, toileting and personal hygiene.

A request on 12/12/17 for the resident's shower records for the previous 2 months revealed the resident received a shower on 11/18/17 and 11/25/17 only.

4. The Minimum Data Set (MDS) Assessment tool dated 11/2/17 revealed Resident #6 had

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diagnoses that included diabetes, depression and Alzheimer's disease and experienced moderate cognitive impairment. The MDS documented Resident #6 required extensive assist of 2 or more staff for transfers, bathing, dressing, toilet use, and personal hygiene, and had frequent bowel and bladder incontinence.

A request on 12/12/17 for the resident's shower records for the previous 2 months revealed the resident received showers on 10/18/17, 11/15/17, 11/18/17 and 11/25/17 only.

5. The Minimum Data Set (MDS) Assessment tool dated 10/4/17 revealed Resident #7 had diagnoses that included hydrocephalus (excess fluid on the brain) and hemiplegia (paralysis on 1 side of the body), and displayed intact cognition. The MDS documented the resident required extensive assist of at least 2 staff for transfers, bathing, dressing, toilet use and personal hygiene. The MDS also documented the resident experienced frequently bowel and bladder incontinence.

A request on 12/12/17 for the resident's shower records for the previous 2 months revealed the resident received a shower on 10/15/17.

During an interview on 12/13/17 at 9:28 a.m., the resident stated he had received showers once a week, if that, in the previous months because the facility didn't have enough staff.

6. The Minimum Data Set (MDS) Assessment tool dated 9/18/17 revealed Resident #9 had diagnoses that included Alzheimer's disease, anxiety and depression, and displayed severe cognitive impairment. The MDS documented the

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resident required extensive assist of 2 or more staff for transfers, bathing, dressing, toilet use, and personal hygiene. The MDS revealed the resident was always incontinent of bowel and bladder.

A request on 12/12/17 for the resident's shower records for the previous 2 months revealed the resident received showers on 11/25/17 and 12/5/17.

7. The Minimum Data Set (MDS) Assessment tool dated 10/9/17 revealed Resident #10 had diagnoses that included seizure disorder and intracranial injury, and displayed severe cognitive impairment. The MDS documented the resident required extensive assist of 2 staff for transfers, bathing, dressing, toilet use, and personal hygiene. The MDS also documented the resident received all nutrition and hydration via enteral feeding tube, and was always incontinent of bowel and bladder.

A urine incontinence problem identified on the resident's nursing care plan directed staff to provide incontinence care as needed.

An alteration of comfort problem identified on the nursing care plan directed staff to reposition the resident frequently.

During an interview on 12/13/17 at 2:20 p.m., the resident's elderly family member and alternate responsible party stated he/she visited the resident at least 5 times a week, arrived around 9 p.m. on 12/9/17 and smelled urine from the resident's doorway and his bed was soaked with urine. He/she located a certified nursing assistant (CNA) who said she was the only CNA that

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evening on the resident's hall; the CNA assisted him/her with incontinence care, repositioned the resident, and placed pillows under both the resident's arms. The family member reported he/she returned the following morning between 8 and 9 a.m. and found the resident in the same position, the bed and bedding soaked with urine, and the pillows tucked exactly as he/she had left them the evening before. The family member stated there were 3 incontinence brief's in the resident's drawer before he/she provided the care that morning, and he/she marked the brief placed on the resident. When he/she returned that evening around 9 p.m., the bed was soaked with urine, the resident in the same position with the same marked incontinence brief, and 2 briefs remained in his drawer. The family member stated he/she had spoken with the former director of nursing (DON) approximately 2 months ago and again 3 weeks ago about lack of staff continuity and lack of staff, spoke with the DON again on the morning of 12/11/17 when the DON stated she was at the facility on 12/10/17, and staff reported that he/she was upset. The family member reported the resident's skin was very red, with deep ridges where he lay on wrinkles in the bedding when he/she provided the care. The family member stated the the DON's responses to his/her concerns were the facility was attempting to hire more staff and didn't address the resident's lack of care.

During an interview on 12/13/17, the former DON stated she had no reason not to believe the resident's family member, if he/she said they provided the only incontinence care the resident received at the time, then that was correct.

During an interview on 12/18/17 at 12:50 p.m. ,

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Staff E, RN and former unit manager, stated she knew the resident's family member and if they said they provided the only care the resident had, that was correct. Staff E said the family member was frequently at the facility and had marked the resident's incontinence briefs before when he/she suspected the care was not provided and it had been true then, as well.

8. The Minimum Data Set (MDS) Assessment tool dated 9/23/17 revealed Resident #11 had diagnoses that included diabetes, peripheral vascular disease, a cerebrovascular accident (a stroke) and a pressure sore. The MDS documented the resident experienced intact cognition with no symptoms of delirium, and required extensive assist of 2 or more staff for transfers, bathing, dressing, toilet use, and personal hygiene.

Observation on 1/2/18 at 1:10 p.m. revealed the resident positioned in bed, with yellow/orange fingernails that extended at least 1/4 inch to 3/8 inches above the tips of the fingers, with heavy accumulation of debris under all fingernails, and facial hair between 5/8 inch and 1 inch long, and unkempt with particles of food in it.

During an interview at that time, the resident stated the beautician was the last person that shaved him. He reported he did not want the facial hair but had not been assisted by staff to shave or trim his nails and he required that assistance.

During an interview on 1/2/18 at 2:25 p.m., the facility's corporate nurse, Staff J, stated she had directed staff to provide a manicure and trim the resident's fingernails that day.

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| F 677 | Continued From page 33<br><br>During an interview on 12/12/17 at 1:20 p.m., the facility's volunteer Ombudsman stated she visited the facility monthly. Residents and their family members had complained to her for the last 3 months that they had not received showers or showers/baths were not provided as often as needed. She reported she had spoken to the administrator about it in November.<br><br>During an interview on 12/14/17 at 6:30 p.m., Staff P, registered nurse (RN), stated she worked at the facility until December, 2017 and said residents complained they weren't getting showers, sometimes for 2 weeks or more. She reported she phoned the administrator's office, handed the phone to the resident, and directed the resident to tell the administrator they hadn't had a shower; after that, they received a shower. She stated she had done that at least 3 times for different residents. Staff P stated there had been staffing shortages at the facility since late summer. | F 677 | | |
| F 684 SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and resident and staff | F 684 | | |

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interviews, the facility failed to provide services according to professional standards and according to physician orders for 1 of 15 resident records reviewed. (Resident #3). The facility reported a census of 79 residents.

Findings include:

1. The Minimum Data Set (MDS) Assessment tool dated 10/10/17 revealed Resident #3 had diagnoses that included diabetes, cancer, and malnutrition. The MDS documented the resident received nutrition via enteral feeding though a jejunostostomy tube (J-tube).

Physician orders directed staff to cleanse the J-tube insertion site with wound cleanser, apply bacitracin ointment around tube site and cover with split 4 inch by 4 inch gauze 2 times daily and as needed.

Monthly treatment administration records (TAR) reports revealed the resident's ordered wound care was not provided as ordered on:

9/8/17, 9/11/17, 9/12/17, 9/16/17, 9/18/17, 9/20/17, 9/23/17, 9/24/17, 9/25/17, 9/27/17, 9/29/17, 10/3/17.

On 10/23/17, physician orders directed staff to cleanse the J-tube insertion site with wound cleanser, apply bactroban around insertion site and cover with split 4 inch by 4 inch gauze 2 times daily and as needed.

Monthly TAR reports revealed the resident's ordered wound care was not provided as ordered on these dates, 11/4/17, 11/6/17, 11/7/17, 11/9/17 and 11/16/17.

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| F 684 | Continued From page 35<br><br>Staff interviews revealed:<br><br>1/3/18 at 2:46 p.m., Staff D, registered nurse (RN), stated she worked at the facility for 2 months, quit approximately 2 weeks ago, there was never enough staff, the nurses couldn't do all their assigned duties as a result.<br><br>12/14/17 at 6:50 a.m., Staff B, licensed practical nurse (LPN), stated she was scheduled to work on the lower level from 6 a.m. to 6 p.m. on 12/9/17 and 12/10/17, stayed until 10 p.m. on 12/10/17, the staffing was bad as there were only 2 CNA's on the floor from 6 p.m. to 10 p.m. | F 684 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(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<br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and resident, family and staff interviews, the facility failed to provide the necessary care and service | F 686 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 686 | Continued From page 36<br>to promote healing and prevent infection for 1 of 2 resident's reviewed with pressure sores (Resident #2). The facility reported a census of 79 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) Assessment tool dated 12/22/17 revealed Resident #2 had diagnoses that included quadriplegia (paralysis below the neck), depression, and a Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle), present on admission (6/9/17), that measured 2.5 centimeters (cm), by 2.6 cm by 2.0 cm depth, with granulation tissue present, scored 15 out of 15 points on the Brief Interview for Mental Status (BIMS) cognitive assessment and without symptoms of delirium, required extensive assistance by at least 1 staff for reposition in bed, eating, toileting and personal hygiene, and extensive assistance by 2 or more staff for dressing, transfers to and from bed and chair and bathing.<br><br>An activity of daily living (ADL) assistance problem initiated on 6/11/17 on the nursing care plan directed staff to:<br><br>1. Encourage and/or assist the resident to reposition.<br>2. Continue to reposition even if asleep.<br><br>A potential for skin breakdown related to colostomy problem initiated on 9/20/17 on the nursing care plan directed staff to:<br><br>1. Report changes in bowel movement frequency, consistency or control. | F 686 | | |

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| F 686 | Continued From page 37<br>2. Change ostomy appliance as needed.<br><br>Physician orders directed:<br><br>1. 8/12/17 - Cleanse sacral ulcer with normal saline, pat dry, pack with Melgisorb alginate AG or equivalent with cotton tipped applicator, cover with Allevyn foam dressing, change dressing every other day and as needed.<br><br>2. 1/8/18 - Cleanse sacral ulcer with normal saline, pat dry, pack with Melgisorb alginate AG or equivalent with cotton tipped applicator, cover with Allevyn foam dressing, change dressing daily and as needed.<br><br>Stage 4 pressure sore wound measurements on previous MDS Assessments revealed:<br><br>1. 6/16/17 - 3.5 cm by 3.0 cm by 0.8 cm depth, slough tissue present.<br>2. 9/15/17 - 2.8 cm by 1.8 cm by 0.8 cm depth, granulation tissue present.<br>3. 10/4/17 - 3.0 cm by 2.0 cm by 1.6 cm, granulation tissue present.<br>4. 10/25/17 - 4.0 cm by 3.0 cm by 2.0 cm depth, granulation tissue present.<br>5. 12/22/17 - 2.5 cm by 2.6 cm by 2.0 cm depth, granulation tissue present.<br><br>A request on 1/16/18 for the resident's wound assessments resulted in 1 pressure ulcer assessment document completed on 12/14/17.<br><br>Monthly treatment administration records (TAR) reports, reviewed on 1/16/18, revealed the resident's ordered wound care was not provided as ordered on these dates: | F 686 | | |

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| F 686 | Continued From page 38<br>12/18/17 and 12/30/17, and refused on 12/22/17, 12/24/17 and 1/1/18 without follow-up attempts.<br><br>A history and physical form from a wound center transcribed on 1/8/18 revealed the resident's chronic sacral ulcer assessed, the resident had received wound care every other day, the physician preferred daily wound care, surgical repair and closure of the pressure sore required and the physician planned for the surgical procedure scheduled in the near future.<br><br>The Non Sterile Dressing Change policy dated 4/2016 directed staff:<br><br>1. Disinfect over bed table using an EPA approved disinfectant.<br>2. Place a clean barrier on the over bed table, then place hand sanitizer, equipment and supplies on top of the barrier.<br>3. Perform hand hygiene.<br>4. Position resident to expose area for treatment.<br>5. Place procedure towel or clean towel under area for treatment.<br>6. Perform hand hygiene and apply gloves.<br>7. Remove soiled dressing and discard.<br>8. Remove soiled gloves, discard and perform hand hygiene.<br>9. Arrange supplies on table, open packages to reveal supplies, cut dressing to size if applicable with clean scissors (disinfect with an EPA approved disinfectant before and after using).<br>10. Perform hand hygiene and apply gloves.<br>11. Cleanse wound per order, clean from center of wound moving outward. Clean wound then peri wound.<br>12. Remove and discard soiled gloves.<br>13. Perform hand hygiene and apply gloves.<br>14. Apply dressing per physician order, apply tape | F 686 | | |

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| F 686 | Continued From page 39<br>with initials and date of dressing change to secure dressing.<br>15. Remove procedure towel and discard.<br>16. Remove soiled gloves, discard, perform hand hygiene, apply gloves.<br>17. Disinfect over bed table with an EPA approved disinfectant.<br>18. Remove soiled gloves, discard, perform hand hygiene.<br>19. Return equipment and used supplies to designated area.<br><br>Observation of the pressure sore when wound care provided on 1/16/18 at 9:07 p.m., by Staff C, licensed practical nurse (LPN), revealed:<br><br>1. An opened package of Melgisorb alginate AG, removed from a plastic drawer in the resident's room, and a bag of cotton tipped applicators, a bag of 4 inch by 4 inch non-sterile gauze pads, a packaged Allevyn dressing and 2 vials of normal saline obtained from the treatment cart, all placed on the resident's over bed table without a barrier, and without first sanitizing the surface.<br>2. Staff C left the room at 9:17 p.m. and returned at 9:18 p.m. with a pair of scissors, wound measurement tool, and several individual alcohol wipe packets, and placed it all on the same over bed table without a barrier. Staff C wiped the scissors with 3 different alcohol pads and placed the scissors back on the overbed table without a barrier, with all supplies placed in close proximity on an approximate 12 inch by 12 inch area.<br>3. Staff C washed their hands, applied gloves, placed the resident's urine drainage bag on top of the resident's bed, pulled the bedding away from the resident's sacral wound area with resident positioned on her side, then removed the sacral dressing without changing gloves or sanitizing | F 686 | | |

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their hands.
4. Staff C removed dressing and packing material revealed dark tan drainage, the wound bed was dull pink/tan colored in appearance with slough tissue.
5. Staff C obtained wound measurements of 3.4 cm by 1.8 cm by 2.4 cm depth, with undermining of the entire wound area measured as 1.9 cm at 1 o'clock, 2.6 cm at 3 o'clock, 2.6 cm at 9 o'clock, 1.9 cm at 11 o'clock, and tunneling of the wound present at 1 o'clock.
6. Staff C removed their gloves, sanitized their hands, applied gloves, and held folded gauze pads below the wound in 1 hand as she squirted the saline into the wound with the other. She then discarded the gauze, repeated the procedure, and had staff tilt the resident toward her to drain the irrigation fluid.
7. Staff C changed gloves, cut the Melgisorb to size, used a cotton tipped applicator and placed it in the wound.
8. Staff C changed gloves, applied the Allevyn dressing with date written on it, removed gloves and sanitized her hands.
9. Staff C gathered the wound supplies, but did not sanitize the over bed table after the procedure. She then returned the supplies to the treatment cart.

Resident and family member interviews conducted on 12/18/17 at 4:15 p.m. revealed they reported to nursing staff and the director of nursing (DON), multiple times, the resident was not repositioned at 2 hour intervals as needed and required throughout the night and when in bed. The family member reported the resident was left in the same position for 5 or more hours at a time, the resident knowledgeable and aware of this by the clock on her cell-phone, and she

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experienced pain and discomfort in her shoulders and back when left in the same position for longer than 2 hours. The family member reported the DON always said she would direct staff to reposition the resident every 2 hours, staff efforts might change for a day or 2, then revert to previous practices and not reposition the resident at 2 hour intervals. The resident stated she had text messages on her cell phone, from the DON, that staff were reminded to reposition her every 2 hours.

During an interview on 1/8/18 at 6:50 p.m., the resident's family member stated he/she attended the wound center appointment with the resident earlier that day and was appalled, the resident had sores before but nothing like that; it was a big hole. The doctor asked whether or not staff repositioned her every 2 hours and how often they changed the dressing.

During an interview on 1/16/18 at 4:01 p.m., the resident stated her colostomy bag often filled with air and staff were required to check the status and empty the air every couple hours, but they don't. She reported the colostomy bag bursts, the fecal contents drain onto the bed and has came into contact with her wound. She commented staff don't change her bed promptly when it occurs.

Staff interviews revealed:

1/3/18 at 2:46 p.m., Staff D, registered nurse (RN), stated she worked at the facility until 12/2017, there was never enough staff, nurses couldn't always do all treatments and assigned responsibilities, and they relied heavily on agency staff for nurses and aides (certified nursing

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assistants). She said she had spoken to the director of nursing about the staffing problems and the staffing did not improve.

1/22/18 at 7:20 p.m., Staff E, RN and former unit manager, stated staffing was a problem at the facility, the treatments and dressing changes were not always done if there were not enough nurses or certified nursing assistants (CNA's), and the facility used several agencies for supplemental staff. She stated agency staff were not familiar with residents or routines and required treatments were not always done. Staff E stated Resident #2 often complained that staff had not repositioned her as required, sometimes it was true, other times she had worked on the night shift, made sure the resident was repositioned and the resident wouldn't remember that she had done so.

12/18/17 at 11:03 p.m., the former director of nursing (DON), stated the facility wound nurse was required to assess wounds weekly, however, the facility didn't have a wound nurse at the time. She said unit managers and the DON were currently responsible for the assessments, and pressure sore assessments were documented weekly on a PUSH wound tool.

3. The Minimum Data Set (MDS) Assessment tool dated 11/23/17 revealed Resident #5 had diagnoses that included diabetes, arthritis and peripheral vascular disease.

Physician orders directed staff to cleanse left ankle wound with acetic acid, apply a Hydrogel gel dressing, cover with thick foam, wrap with rolled gauze and secure with net dressing daily.

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| F 686 | Continued From page 43<br><br>Monthly treatment administration records (TAR) reports revealed the resident's ordered wound care was not performed as ordered on:<br><br>9/12/17, 9/23/17, 9/24/17, 9/25/17, 9/26/17, 9/27/17, 9/29/17, 10/3/17, 10/14/17 and 10/19/17.<br><br>Physician orders directed staff to thoroughly cleanse and dry foot, apply zeroform dressing to the 3 wounds, cover with ABD gauze, secure with rolled gauze and Sepronent twice daily.<br><br>Monthly TAR reports revealed the resident's ordered wound care was not performed as ordered on:<br><br>11/2/17, 11/3/17, 11/4/17, 11/6/17, 11/7/17, 11/8/17, 11/9/17, 11/16/17 and 11/17/17<br><br>4. A history and physical dated 7/20/17 revealed Resident #13 had diagnoses that included aortic stenosis, atrial fibrillation and renal failure.<br><br>Physician orders directed staff to paint all affected areas on feet with Betadine and wrap with rolled gauze daily.<br><br>Monthly treatment administration records (TAR) revealed the resident's ordered wound care was not performed as ordered on:<br><br>8/5/17, 8/6/17, 8/9/17, 8/10/17 and 8/13/17.<br><br>5. The Minimum Data Set (MDS) Assessment tool dated 10/1/17 revealed Resident #15 had diagnoses that included diabetes and peripheral vascular disease. | F 686 | | |

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| F 686 | Continued From page 44<br>Physician orders directed staff to cleanse wound on right heel with normal saline, apply Silver Sulfadiazine cream and cover with 4 inch by 4 inch gauze twice daily.<br><br>Monthly treatment administration records (TAR) revealed the resident's ordered wound care was not performed as ordered on:<br><br>9/19/17, 9/24/17, 9/28/17, 9/29/17, 9/30/17, 10/2/17, 10/7/17, 10/9/17, 10/10/17, 10/11/17, 10/13/17, 10/25/17, 11/5/17 and 11/7/17. | F 686 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to provide adequate supervise when repositioning a resident in bed, resulting in the resident falling out of bed and hitting head on trash can which resulted in a closed head injury and lumbar fracture (Resident #6) and failed to provide adequate supervision in order to keep Resident #16 safe. The sample consisted of 20 residents reviewed and the facility reported a census of 79 residents<br><br>1. Resident #6 had a Minimum Data Set (MDS) assessment with a reference date of dated | F 689 | | |

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| F 689 | Continued From page 45<br>11/2/17 . The MDS identified the resident had diagnosis that included diabetes, arthritis, Alzheimer's disease and depression. The MDS indicated the resident had a score of 11 out of 15 for Brief Interview of Mental Status (BIMS) cognitive assessment. A score of 11 identified the resident had a moderate cognitive impairment. The MDS indicated the resident had no symptoms of delirium, and required extensive assistance by 2 or more staff members for transfers to and from bed and chair, bathing, dressing, toileting, personal hygiene, and frequently incontinent of bowel and bladder.<br><br>The Care Plan, identified the resident had a problem with activity of daily living skills. The plan directed staff to assist the resident with dressing, bathing, personal hygiene and transfers.<br><br>The physician orders directed staff to apply Calmoseptine ointment (moisture barrier) to the buttocks topically every shift for redness and excoriation.<br><br>An Incident Report, completed by Staff A, licensed practical nurse (LPN), dated 1/1/17 at 6:30 a.m. identified the resident rolled out of bed when changed ( due to incontinency) by staff, hit face on garbage can and the staff used a mechanical lift to transfer the resident from the floor.<br><br>A hospital Emergency Department physician note, dated 11/1/17 at 8:50 a.m. indicated the resident assessed after a fall, and later admitted to the hospital for a closed head injury and facial swelling after a fall from the bed. The Final Report of the images included a compression | F 689 | | |

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| F 689 | Continued From page 46<br>fracture at L2 (lumbar) and a chronic fracture of the lower Thorasic spine, T 12.<br><br>The resident returned to the facility on 11/2/17 at 2:30 p.m., with 2 bruises on the left side of the neck that measured 10 centimeters (cm) by 3.5 cm and 7 cm by 2 cm, both purple colored.<br><br>On 1/4/18 at 8:10 a.m., Staff A was interviewed and stated on the morning of 11/1/17, the resident became incontinent and as she removed the soiled bedding with the resident positioned on her side, the resident and the air mattress slid off the opposite side of the bed and the resident hit her head on the waste can as she fell to the floor. There were no other staff in the room at the time. Staff A stated she should not have provided the care unassisted.<br><br>On 2/27/18 at 1:01 p.m. Staff A was interviewed and stated the resident fell off the left side of the bed in between her and the room- mate's bed. Staff A stated the area had a trash can and a recliner chair on that side of the bed. The air mattress was partially hanging over that side of the bed but still mostly on the bed with the sheet over the mattress. The bed was in the normal position and was not a low bed but she had raised the bed up for the care. The bed had no bed rails on the bed. Staff A stated after the incident, she yelled for help and another nurse and a CNA came in quickly.<br><br>2. The MDS with a reference date of 8/16/17 indicated Resident #16 had diagnoses that included aphasia (difficulty with speech), hemiplegia (paralysis of 1 side of the body) and hypertension (high blood pressure), severe | F 689 | | |

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cognitive impairment, required assistance of at least 2 staff for transfers to and from bed and chair, bathing, dressing, eating, toileting and personal hygiene, always incontinent of bowel and bladder, unable to stand or ambulate, and deficits of bilateral upper and lower extremities.

The Care Plan indicated the resident had a deficit with activity of daily living (ADL) self-care. The plan directed the staff that 2 staff needed to assist the resident with dressing, transfers and bathing. Another problem identified on 5/23/15, reflected the resident to be at risk for falling. The interventions directed the staff to change the resident's positions slowly, place commonly used articles in reach and reinforce the need to call for assistance.

An Incident Report, created on 11/1/17 at 2:27 p.m. identified the resident found on the floor on 10/30/17 at 6:15 p.m. by her bed, with sheet under her and incontinent of urine, without major injury, no mental status changes, pupils equal and reactive to light, grips equal, range of motion within normal limits for the resident, resident crying, unable to determine if crying was due to pain or some other reason. The staff assisted the resident to bed.

Another Incident Report, created on 10/14/17 at 1:15 p.m., revealed the staff found the resident on the bedroom floor at 10:45 a.m. on her back with feet up in air against side of the bed. No injuries identified.

Staff interviews identified the following:

12/18/17 at 10:52 a.m., Staff K, licensed practical nurse (LPN), on duty at time of the fall on

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| F 689 | Continued From page 48<br>10/30/17, stated she didn't know how the resident fell, it happened at the change of shifts, the resident didn't attempt to self transfer.<br><br>12/18/17 at 12:10 p.m., Staff BB, LPN, stated the resident could not move by herself, she had contractures.<br><br>12/18/17 at 12:25 p.m., Staff L, LPN, stated she never saw the resident move.<br><br>12/18/17 at 12:43 p.m., Staff M, LPN, stated the resident couldn't move on her own.<br><br>1/23/18 at 3:30 p.m., Staff G, certified nursing assistant (CNA) stated the resident didn't move on her own, she had to be fed, she didn't know how she could have fallen on her own.<br><br>12/18/17 at 5:20 p.m., the former Director of Nursing (DON) stated the resident could scoot herself in bed, and she didn't have any investigative note or file related to he 10/30/17 fall. | F 689 | | |
| F 725 SS=E | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required | F 725 | | |

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| F 725 | Continued From page 49<br>at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and resident, family member and staff interviews, the facility failed to provide sufficient nursing staff to meet all needs of the residents. The facility reported a census of 79 residents.<br><br>Findings include:<br><br>A Resident Census and Conditions of Resident report dated 12/11/17 revealed the facility had a census of 80 residents with the following conditions:<br><br>50 occasionally or frequently incontinent of bladder<br>28 occasionally or frequently incontinent of bowel<br>2 with intellectual and/or developmental disability<br>18 with dementia<br>4 with behavioral healthcare needs<br>8 with pressure sores<br>14 received respiratory treatments | F 725 | | |

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| F 725 | Continued From page 50<br>1 received tracheostomy care<br>5 received ostomy care<br>3 received enteral feedings<br>10 with unplanned significant weight loss or gain<br><br>Observation with the former director of nursing (DON) on 12/11/17 at 2:50 p.m. on the facility's lower level revealed 2 certified nursing assistants (CNA's) on duty, scheduled from 2 p.m. to 10 p.m., and 3 nurses on duty, scheduled until 6 p.m. at their shift change. The staff on duty reported a census of 65 residents on that floor, 29 that transferred with mechanical lift (required 2 staff members), and 3 residents required 2 staff for transfer without mechanical lift. During an interview at that time, the DON stated there wasn't agency staff available for work, their scheduler was a CNA, she would have her report to the floor at 6 p.m., and she would reassign 1 of the CNA's from the upper level to the lower level.<br><br>Review of actual staff hours verified by payroll records on 12/9/17 and 12/10/17 for the lower level revealed the following:<br><br>12/9/17<br>3 CNA's and 2 nurses on duty between 6 p.m. and 10 p.m.<br><br>3 CNA's and 1 nurse on duty between 10 p.m. and 6 a.m. on 12/10/17<br><br>12/10/17<br>3 CNA's on duty from 6 a.m. to 2 p.m., a 4th CNA sent home at 8:30 a.m.<br>3 nurses and another nurse on orientation on duty from 6 a.m. to 6 p.m.<br><br>2 CNA's on duty from 2 p.m. to 10 p.m. | F 725 | | |

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| F 725 | Continued From page 51<br>3 nurses on duty from 6 p.m. to 10 p.m.<br><br>2 CNA's on duty from 10 p.m. to 6 a.m.<br>2 nurses on duty from 10 p.m. to 6 a.m.<br><br>On 12/12/17 at 2:30 p.m., a family member and alternate responsible party for Resident #10 stated he/she visited the resident at 9 p.m. on 12/9/17, the resident in a urine soaked bed, he/she provided the required care with the only CNA on the resident's hall, when he/she returned between 8 a.m. and 9 a.m. on 12/10/17, the resident had not received any care since the evening before, found saturated with urine again, the family member performed the required care, marked the incontinence brief applied to the resident, returned later that day at 9 p.m. and found the resident in the same marked brief in a urine soaked bed and not repositioned since they left earlier that day.<br><br>On 1/18/18 at 11:40 a.m., Resident #25's responsible party stated he/she visited the resident daily, the resident dependent for all care, the facility very short staffed, reliant on agency staff that are not aware of the residents routines and the facility had a hard time keeping good staff.<br><br>On 12/13/17 at 9:28 a.m., Resident #7, interviewable and dependent on staff for care, stated he has waited over an hour for assistance when call light used, that has happed once or twice a week, has waited more than 30 minutes for assistance several times a week, the facility doesn't have enough CNA's, he sees new staff faces all the time and they are not familiar with his care routine. | F 725 | | |

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| F 725 | Continued From page 52<br><br>Staff interviews revealed:<br><br>1/3/18 at 2:46 p.m., Staff D, registered nurse (RN), stated she worked at the facility for 2 months, quit approximately 2 weeks ago, there was never enough staff, the nurses couldn't do all their assigned duties as a result.<br><br>12/14/17 at 6:50 a.m., Staff B, licensed practical nurse (LPN), stated she was scheduled to work on the lower level from 6 a.m. to 6 p.m. on 12/9/17 and 12/10/17, stayed until 10 p.m. on 12/10/17, the staffing was bad as there were only 2 CNA's on the floor from 6 p.m. to 10 p.m.<br><br>1/18/18 at 5:45 p.m., Staff E, RN and former unit manager of the lower level stated a minimum of 4 CNA's were required on the evening shift with the residents currently at the facility, 2 or even 3 CNA's on the evening shift would not be able to meet the residents' needs. | F 725 | | |
| F 760 SS=G | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff and physician interviews and review of policy and procedures, the facility failed to ensure that 1 of 19 residents reviewed were free from significant medication errors (Resident #17). The facility reported a census of 79 residents.<br><br>Findings include: | F 760 | | |

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| F 760 | Continued From page 53<br><br>The Minimum Data Set (MDS) assessment, with a reference date of 9/4/17, indicated Resident #17 had an admission date into the facility on 8/28/17 with diagnoses that included coronary artery disease, history of venous thrombus and emboli (blood clots) and aortocoronary bypass graft (heart vessel bypass). The MDS indicated the resident required extensive assistance of at least 1 staff for transfers to and from the bed and chair, bathing, dressing, toileting and personal hygiene. The physician orders that directed the resident's admission included:<br><br>1. Clopidogrel Bisulfate (Plavix - a medication used to prevent blood clot formation following coronary vessel bypass procedures) 75 milligrams (mg) administered oral daily.<br><br>2. Apixaban (Eliquis - an anticoagulant medication) 5 mg administered oral 2 times daily.<br><br>The facility's Admission policy, dated 12/2009, directed staff to notify physician of resident admission and obtain or verify orders.<br><br>The policy and procedures titled Medication and Treatment Administration Guidelines, dated 12/2014, directed that orders are transcribed and noted by the licensed nurse. The licensed nurse noting an order is responsible for accurate transcription and initiation of orders.<br><br>The August, 2017 and September, 2017 Medication Administration Records (MAR's) revealed Resident #17 received the Plavix medication daily as ordered from 8/29/17 through 9/5/17, and had not received the Eliquis medication. | F 760 | | |

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| F 760 | Continued From page 54 | F 760 | | |

A Nurse's Progress Note transcribed on 9/6/17 at 6:29 a.m. by Staff A, licensed practical nurse (LPN), revealed the spouse informed the nurse the resident's leg was swollen. The nurse assessed the leg and described the leg as edematous (swollen), hard and warm to touch, the physician notified, and obtained an order for a Doppler study.

A Nurse's Progress note transcribed on 9/6/17 at 6:28 a.m., by Staff B, LPN (licensed practical nurse) indicated the physician ordered the resident sent to the hospital Emergency Room for evaluation and treatment related to deep vein thrombus (DVT) to the right hip and right lower extremity.

A hospital discharge summary dated 9/12/17 revealed the resident admitted on 9/6/17, with diagnoses that included an acute DVT of the right lower extremity, a chronic DVT of the left lower extremity, the resident had not received the ordered Eliquis medication while at the nursing home, and required a surgical procedure, a thrombectomy (blood clot removed through an incision) on 9/8/17, and remained hospitalized until 9/11/17.

Documentation on a facility self-reported event to the Iowa Department of Inspections and Appeals (DIA), identified Resident #17 admitted on 8/28/17, sent to the emergency Room on 9/5/17 for right leg swelling with redness, admitted to the hospital for DVT, and a hospital surgeon contacted the facility on 9/6/17 and questioned if the resident had received the Plavix and Eliquis medications as ordered.

On 12/11/17 at 5:22 p.m., the Director of Nursing

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| F 760 | Continued From page 55<br>(DON) was interviewed and stated 2 different nurses were required to enter physician orders upon a resident's admission; 1 that entered the orders in the computer and the 2nd nurse verified the order for accuracy. The DON stated Staff K, licensed practical nurse (LPN), entered the orders on the resident's admission, omitted the Eliquis order, and no other nurse verified the orders were entered as prescribed.<br><br>On 1/18/17 at 11:15 a.m., the resident's cardiothoracic surgeon was interviewed and stated staff should have administered both the Plavix and Eliquis medications as ordered, and if administered as directed, it would have eliminated or greatly reduced the resident's risk of blood clot development that required his re-hospitalization and surgical intervention. | F 760 | | |

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This plan of correction represents the center's allegation of compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of the Iowa Department of Public Health. Preparations and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

**F558**
*The facility strives to ensure that the resident receives the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences and provide care that maintains each resident's dignity.*

***Corrective action taken for residents found to have been affected by deficient practice***

Resident #2 was reviewed and assessed for adverse physical and/or psychosocial effects related to personal hygiene, ostomy care and providing privacy during care. Plan of care updated to reflect residents needs and preferences.

Resident # 10 was reviewed and assessed for adverse physical and/or psychosocial effects related to repositioning assistance and incontinence care. Plan of care updated to reflect residents needs and preferences.

***How the center will identify other residents having the potential to be affected by the same deficient practice.***

Residents residing in the facility that require assistance with activities of daily living are at risk of being affected and have been reviewed.

***What changes will be put into place to ensure that the problem will be corrected and will not recur.***

- Nursing staff will be reeducated on providing ostomy care, repositioning and incontinence care as indicated and maintaining privacy during the completion of care.
- The Director of Nursing (DON)/designee will complete random audits on 5 residents weekly times four weeks to validate completion of repositioning assistance, ostomy care and personal hygiene assistance to include incontinence care.

***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.***

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance

***Date when corrective action will be completed.*** March 10, 2018

**ManorCare Health Services-West Des Moines**
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**F580**
*It is the practice of this facility to ensure proper notification to the resident's responsible party of a change in resident condition.*

***Corrective action taken for residents found to have been affected by deficient practice***
Resident #16 no longer resides in the facility.

***How the center will identify other residents having the potential to be affected by the same deficient practice.***

Residents residing in the facility who have had a fall have the potential to be affected. The center has reviewed current residents who have had a fall and has ensured notification to the residents' responsible party as indicated.

***What changes will be put into place to ensure that the problem will be corrected and will not recur.***

- Licensed Nurses were re-educated on the requirements for notification to the residents' responsible party when a fall has occurred.
- DON or designee will randomly audit 5 residents per week who experience a fall for four weeks to ensure notification of responsible party.

***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.***

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance

***Date when corrective action will be completed.*** March 10, 2018

**ManorCare Health Services-West Des Moines**
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**F584**
*It is the practice of this facility to ensure that the facility maintains a safe, clean and sanitary environment.*

***Corrective action taken for residents found to have been affected by deficient practice***
Resident room #116, # 120 and # 123 have had wallpaper removed, walls cleaned with bleach solvent, Kilz coat applied and primed, painted with new rubber base and caulk to exterior of windows and walls as needed.
Resident # 12 has had no residual affects related to environmental concerns.

***How the center will identify other residents having the potential to be affected by the same deficient practice.***

Like residents were identified as those residents that occupied the 33 rooms identified as having wallpaper have the potential to be affected. The center has completed repairs and improvements to 33 lower level rooms per remediation plan.

***What changes will be put into place to ensure that the problem will be corrected and will not recur.***

- Maintenance Director was educated on proper cleaning methods and preventative maintenance techniques.
- Environmental Services Mgr./Designee to conduct random unit rounds weekly, times four weeks to ensure that any maintenance or environmental issues are continuing to be corrected on a timely basis.

***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.***

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance

***Date when corrective action will be completed.*** March 10, 2018

**ManorCare Health Services-West Des Moines**
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**F604**

*It is the practice of this facility to ensure that residents remain free from physical restraint imposed for convenience and not required to treat the resident's medical symptoms*

***Corrective action taken for residents found to have been affected by deficient practice***
Resident #9 no longer resides in the facility.

***How the center will identify other residents having the potential to be affected by the same deficient practice.***

Residents residing in the facility who require a mechanical lift for transfers and demonstrate physical agitation/aggression during transfers have the potential to be affected. The center has reviewed current residents who require a mechanical lift for transfers with a history of physical agitation/aggression during transfers.

***What changes will be put into place to ensure that the problem will be corrected and will not recur.***

- Nursing staff were re-educated on the Restraint Guidelines to include requirements regarding when a restraint can be utilized.
- DON or designee will randomly audit 5 residents per week for four weeks to ensure there is no use of non-prescribed restraints.

***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.***

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance

***Date when corrective action will be completed.*** March 10, 2018

**ManorCare Health Services-West Des Moines**
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**F607**
*It is the practice of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.*

***Corrective action taken for staff found to have been affected by deficient practice***
Staff "F"- SING background check reflected staff member was cleared for employment.
Staff "H"- No longer employed at the facility.
Staff "G"- Required abuse education completed on 1/9/18.

Employee records have been reviewed for required criminal background checks, appropriate authorization for employee to work and the independent adult abuse training were evaluated for concerns that place residents at high risk for abuse. Any concerns were addressed immediately.

***How the center will identify other residents having the potential to be affected by the same deficient practice.***

Residents residing in the facility have the potential to be affected.

***What changes will be put into place to ensure that the problem will be corrected and will not recur.***

- The facility's QAPI Committee has reviewed the Patient Protection Abuse, Neglect, and Misappropriation Practice Guide and deemed appropriate.

- Human Resource Director was re-educated on how to identify, protect, investigate and report allegations of verbal and physical abuse regarding the criminal background checks, adult abuse education requirements and new hire process according to facility policy.

- Administrator/Human Resource Managers will review new hire criminal background checks weekly for appropriate authorization for employee to work, the completion of the dependent adult abuse training and evaluate for concerns that place residents at high risk for abuse.

***Quality Assurance Plan to monitor performance to make sure corrections is achieved and are permanent.***

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance

***Date when corrective action will be completed.*** February 28, 2018

**ManorCare Health Services-West Des Moines**
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**F620**
*The facility strives to ensure that residents and responsible parties receive authorization for admission and treatment and mandatory written notifications related to the admission.*

***Corrective action taken for residents found to have been affected by deficient practice***

Resident # 16 and # 18 no longer reside in facility.

***How the center will identify other residents having the potential to be affected by the same deficient practice.***
Residents that are newly admitted have the potential to be affected. Admission contracts have been reviewed and updated to ensure proper authorizations and written notifications are in place.

***What changes will be put into place to ensure that the problem will be corrected and will not recur.***

- Admission Director was educated on the requirement to have residents and responsible parties receive authorization for admission and treatment and mandatory written notifications related to the admission.
- Administrator or designee will audit new admissions weekly for four weeks to ensure that Admission Contracts contain required authorizations and written notifications.

***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.***

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance

***Date when corrective action will be completed.*** March 10, 2018

**ManorCare Health Services-West Des Moines**
**5010 Grand Ridge Drive**
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**F623**
*The facility strives to ensure that residents are provided a 48 hour notification of the decision to discharge from skilled therapy services and address residents with special needs and involve responsible party in discharge plan..*

***Corrective action taken for residents found to have been affected by deficient practice***

Resident # 18 no longer resides in the facility

***How the center will identify other residents having the potential to be affected by the same deficient practice.***

Residents that are receiving skilled therapy services and have special needs have the potential to be affected and have been reviewed.

***What changes will be put into place to ensure that the problem will be corrected and will not recur.***

- Social Service staff were educated on the requirement to provide 48 hour notification of the intent to discharge from skilled therapy services and the involvement of the residents responsible party in the discharge plan process.
- Administrator or designee will audit the 48 hour notification process weekly for four weeks to ensure that the intent to discharge from skilled therapy services is delivered timely and the involvement of the resident's responsible party in the discharge plan process has been completed.

***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.***

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance

***Date when corrective action will be completed.*** March 10, 2018

**ManorCare Health Services-West Des Moines**
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**F677**

*It is the policy of the facility to provide necessary services to residents unable to carry out activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene.*

***Corrective action taken for residents found to have been affected by deficient practice***

Resident #3, #5 and #9 no longer reside in the facility.
Resident # 4 had shower provided.
Resident # 6 had shower provided.
Resident # 7 had shower provided.
Resident # 10 was reviewed and assessed related to incontinence care and repositioning.
Resident # 11 had facial hair removed, nails trimmed and shower provided.

***How the center will identify other residents having the potential to be affected by the same deficient practice.***

Like residents are those who are unable to independently complete facial hair care, nail care and require extensive assist with bathing and incontinence care. Identified residents have been reviewed for ADL care.

***What changes will be put into place to ensure that the problem will be corrected and will not recur.***

- Nursing staff will be re-educated on providing facial hair care and nail care as part of the AM care and bathing procedure. Nursing staff will be re-educated on offering and providing incontinence care for residents as indicated.
- The Director of Nursing (DON)/designee will complete random audits on 5 residents weekly times four weeks to validate completion of repositioning assistance and personal hygiene assistance to include incontinence care, nail care, shaving and bathing assistance.

***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.***

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance

***Date when corrective action will be completed.*** March 10, 2018

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**West Des Moines, Iowa 50265**

**F684**
*The facility strives to ensure that the resident receives treatment and care in accordance to with professional standards of practice, the comprehensive person-centered care plan and the residents' choices.*

***Corrective action taken for residents found to have been affected by deficient practice***
Resident #3 no longer resides in the facility.

***How the center will identify other residents having the potential to be affected by the same deficient practice.***
Residents residing in the facility that require J-Tube site treatment are at risk of being affected. The identified residents have been reviewed.

***What changes will be put into place to ensure that the problem will be corrected and will not recur.***

- Licensed Nurses were re-educated on Medication and Treatment Administration Guidelines to reflect treatments to be documented immediately following completion.
- DON or designee will randomly audit Treatment administration completion of 5 residents per week for four weeks.

***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.***

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance

***Date when corrective action will be completed.*** March 10, 2018

**ManorCare Health Services-West Des Moines**
**5010 Grand Ridge Drive**
**West Des Moines, Iowa 50265**

**F686**
*The facility strives to ensure that residents receive necessary care and services to promote healing and prevent infection.*

***Corrective action taken for residents found to have been affected by deficient practice***
Resident # 13 and # 15 no longer reside in facility
Resident #2 pressure ulcer has been assessed and treatment provided as ordered. Ostomy appliance and repositioning plan have been assessed.

***How the center will identify other residents having the potential to be affected by the same deficient practice.***
Residents residing in the facility that have pressure ulcers, have an ostomy and require assistance with repositioning have the potential to be affected. Identified residents have been reviewed.

***What changes will be put into place to ensure that the problem will be corrected and will not recur.***

- Nursing staff was educated on the bed positioning techniques in accordance with the bed positioning policy, ostomy care and pressure ulcer care per facility policy.
- DON or designee will randomly audit 5 residents per week for four weeks to ensure that facility staff are utilizing bed positioning techniques in accordance with the bed positioning, ostomy care and pressure ulcer care policy.

***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.***

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance

***Date when corrective action will be completed.*** March 10, 2018

**ManorCare Health Services-West Des Moines**
**5010 Grand Ridge Drive**
**West Des Moines, Iowa 50265**

**F689**

*The facility strives to provide a safe environment free from accidents hazards and that each resident receives adequate supervision and assistance devices to prevent accidents.*

***Corrective action taken for residents found to have been affected by deficient practice***

Resident #16 no longer resides in the facility.
Resident #6 was assessed for bed mobility and plan of care was reviewed and updated accordingly.

***How the center will identify other residents having the potential to be affected by the same deficient practice.***

Residents who are a two-person assist with bed mobility have the potential to be affected in a similar manner and have been reviewed.

***What changes will be put into place to ensure that the problem will be corrected and will not recur.***

- Nursing staff was educated on the bed positioning techniques in accordance with the bed positioning policy and the falls practice guide.
- DON or designee will randomly audit 5 residents per week for four weeks to ensure that facility staff is utilizing bed positioning techniques in accordance with the bed positioning policy and the post fall's evaluation guide.

***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.***

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance

***Date when corrective action will be completed.*** February 28, 2018

**ManorCare Health Services-West Des Moines**
**5010 Grand Ridge Drive**
**West Des Moines, Iowa 50265**

**F725**
*It is the intent of the facility to provide sufficient nursing and related services to meet the needs of the residents.*

***Corrective action taken for residents found to have been affected by deficient practice***
Resident # 7 was reviewed and assessed for adverse physical and/or psychosocial effects related to call light response and personal care needs.

Resident # 10 was reviewed and assessed related to incontinence care and repositioning.

Resident #25 was reviewed and assessed.

***How the center will identify other residents having the potential to be affected by the same deficient practice.***

Residents residing in the facility have the potential to be affected in a similar manner.

***What changes will be put into place to ensure that the problem will be corrected and will not recur.***

- Staffing levels have been reviewed to ensure appropriate staffing. Additional CNA staff hired and this hiring will continue as indicated.
- Administrator or designee will conduct random weekly reviews of staffing levels to ensure adequate staffing numbers.
- Weekly Interdisciplinary team members (IDT) will conduct random audits to validate completion of personal hygiene assistance to include incontinence care, personal care needs and call light response.

***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.***

Identified concerns shall be reviewed by the facility's QAA Committee.
Recommendations for further corrective action will be discussed and implemented to sustain compliance

***Date when corrective action will be completed.*** March 10, 2018

**ManorCare Health Services-West Des Moines**
**5010 Grand Ridge Drive**
**West Des Moines, Iowa 50265**

**F760**
*The facility strives to ensure that residents are free from significant med errors.*

***Corrective action taken for residents found to have been affected by deficient practice***
Resident #17 no longer resides in the facility.

***How the center will identify other residents having the potential to be affected by the same deficient practice.***
Residents residing in the facility that receive Plavix and or Eliquis are at risk of being affected. The identified resident's physician's orders have been reviewed.

***What changes will be put into place to ensure that the problem will be corrected and will not recur.***

- Licensed Nurses were re-educated on Medication and Treatment Administration Guidelines to reflect accurate transcription and initiation of medication orders.
- DON or designee will randomly audit new admission medication transcription orders of 5 residents per week for four weeks.

***Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent.***

Identified concerns shall be reviewed by the facility's QAA Committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance

***Date when corrective action will be completed.*** February 28, 2018