STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. BUILDING _____ B. WING _____	C 10/05/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 10-27-18 Complaint #77167-C was investigated and substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and manufacturers recommendations, the facility failed to provide appropriate positioning on an alternating air mattress and utilize the proper control settings to assure appropriate pressure relief for 2 of 4 residents with pressure ulcers and/or skin issues. (Resident #1 and #4) The facility identified a census of 82 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form	F 686	The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it. **<u>This constitutes my credible allegation of compliance as of October 27th, 2018.</u>** **F686** **<u>Correct to the individual:</u>** R #1 and R #4 plan of care was reviewed and revised initially on 10/1/18 thru 10/18/18.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawna Marshall — TITLE: NHA — (X6) DATE: 10/25/18

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

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F 686	Continued From page 1 dated 9/18/18, Resident #1 had diagnosis that included respiratory failure, tracheostomy, quadriplegia, Parkinson's disease, diabetes mellitus (DM) and contractures. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) (measures cognitive status) score off 13 out 15, non ambulatory, dependent on 2 staff with bed mobility, transfers, locomotion, dressing, personal hygiene and toilet use. The assessment indicated the resident as at risk for pressure ulcers, moisture associated skin damage, application of non surgical dressings and ointments/medications. A Care Plan with a focus area dated 4/26/18 indicated the resident had a pressure ulcer or a potential for pressure ulcer development. The interventions include the following: a. Treatments as ordered. b. Follow facility policies/protocols for prevention/treatment of skin breakdown. An observation 9/27/18 at 3:15 a.m., revealed the resident positioned in bed on a rotating air mattress device covered with a top sheet, turn sheet folded in 1/2 and a disposable incontinent pad. An observation 9/28/18 ay 11:32 a.m. revealed Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA as they transferred and positioned the resident in bed on a rotating air mattress device layered with a top sheet, a bath blanket folded in 1/2 and a disposable incontinent pad. During an interview at the same time Staff A confirmed the layering. An observation 10/4/18 at 3:12 p.m. revealed	F 686	**Protect residents in similar situation;** Nursing Staff in-serviced on appropriate control settings and coverings on alternating air mattresses from 10/12/18 to 10/18/18. **Measure/system prevents re-occurrence:** The facility does provide cares consistent with professional standards of practice to prevent pressure ulcers. Every resident is assessed at the time of admission, quarterly, annually, and with significant change for skin integrity and the necessary treatments and/or equipment needed to promote healing, prevent infection, and prevent new ulcers from developing. Nursing staff will be instructed to keep appropriate control settings according to manufactures recommendations, as well as, limit the number of coverings on alternating air mattresses to one draw sheet and one disposable chuck under each resident while in bed. QA Nurse and/or designee will provide on-going instructions and administer a competency checklist for each staff on how to appropriately use alternating air mattress.	

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F 686	Continued From page 2 Staff C, CNA and Staff D, CNA weigh the resident via a Hoyer lift device. As the staff lifted the resident from the bed he had been positioned on a rotating air mattress device layered with a top sheet, a folded turn sheet and a disposable incontinent pad. During an interview at the same time Staff C confirmed the layering. 2. A MDS assessment form dated 7/10/18 indicated Resident #4 had diagnosis that included cerebral palsy, DM, arthritis, osteoporosis, depression, unspecified intellectual disabilities, contractures and muscle weakness. The assessment indicated the resident had a BIMS score of 6, dependent on staff with most ADL's, at risk for pressure ulcers and with a stage 3 unhealed pressure ulcer. A Care Plan with a focus area dated 6/5/18 documented the resident had actual impairment/injury to her skin integrity related to / fragile skin, incontinence, a history of pressure areas, debility and cerebral palsy. The approaches included the following: a. The resident required a low air loss mattress to protect the skin while in bed. Review of the resident's weights revealed the following: a. 9/20/18 - 110 # b. 9/27 - 100. 4# c. 10/3 - 107.2 # An observation 9/28/18 at 9:45 a.m. revealed the resident positioned on a low air loss rotating air mattress with a firm setting at 3 (a setting for 140 # person) layered with a turn sheet folded in 1/2,	F 686	**Monitor for permanent solutions:** The QA Nurse and/or designee will conduct weekly audits for the next 60 days to ensure appropriate use and compliance. Any concerns will be immediately addressed. Findings will be reviewed and discussed at the monthly QAPI meeting for resolution.	

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F 686	Continued From page 3 a bath blanket and the resident wore an an incontinent brief. 3. Review of the KAP Medical K-3 and K-4 Mattress (low air loss rotating air mattress) user's guide dated 10/30/13 included the following directives: a. If a sheet must have been used, only use one layer of a loose fitted sheet and never a fitted sheet since it would/may have created a hammocking effect and prevented full immersion. b. Absorbent and breathable under pads may have been used. c. When the patient's weight had been calibrated use firm/soft to calibrate the mattress to the patients estimated body weight (in 35 pound increments).	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff and family interviews, the facility failed to ensure a safe and secure environment for 1 of 4 residents reviewed. (Resident #4) The facility identified a census of 82 residents.	F 689	**F689** **Correct to the individual:** R #4 plan of care was initially revised on 10/5/2018 and reviewed on 10/18/18. **Protect residents in similar situation:** Nursing Staff were re-educated to always be aware of the resident's level of assist according to the plan of care, as well as, the use of patient assistive devices to properly assist with positioning, mobility, and function to keep them safe from 10/12/18 thru 10/18/2018.	

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F 689	Continued From page 4 Findings include: A Minimum Data Set (MDS) assessment form dated 5/6/18 indicated Resident #4 had diagnosis that included cerebral palsy, diabetes mellitus (DM), arthritis, osteoporosis, depression, unspecified intellectual disabilities, contractures and muscle weakness. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 (which identified a cognitive impairment), as dependent on one staff member with bed mobility and non-ambulatory. A Care Plan with a focus area dated 6/5/18 documented the resident as at risk for falls related to (r/t) deconditioning and paralysis r/t cerebral palsy. A Rationale via SBAR for Interventions for Incidents and Falls form dated 6/8/18 stated during cares, preparing the resident for a transfer the resident slid from the air mattress while staff stood on the opposite side of the bed. The resident slid off of the bed legs first. The air mattress surface was noted as slick. A Nursing Documentation and Fall Assessment Form dated 6/8/18 at 4:20 p.m. stated during cares the resident slipped off the opposite side of the bed, legs first then fell to her left side without having hit her head. No apparent injury noted. The resident failed to voice any complaints of pain. A Discharge-Face Sheet form from the hospital dated 6/8/18 documented the resident sustained a finger fracture.	F 689	**Measure/system prevents re-occurrence:** The facility makes every effort to ensure the resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents. Employees are trained by the facility's therapy department on proper transfer techniques, positioning, and equipment use. The facility also conducts an annual "Skills Fair". The QA Nurse and/or designee will monitor and track use of safety, positioning, and assistive devices for each resident to ensure proper function, use, and effectiveness to prevent accidents. Copies of the assistive/safety device logs will be kept on file for the monthly QAPI review.	

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F 689	Continued From page 5 During an interview 10/2/18 at 2:30 p.m. a family member confirmed the resident fell out of bed when the side rail had been positioned up on the side of the bed closest to the door and the staff member stood on the opposite side of the bed while he provided cares which resulted in bruising and a fractured pinky finger. During an interview 10/5/18 at 11:56 a.m. Staff J, Certified Nursing Assistant (CNA) indicated he had been getting the resident ready for supper, dressed her and prepared to place the Hoyer sling device under the resident with the side rail position up. He went to other side of the bed and left the side rail up. He went to turn the resident and the air in the rotating air flow mattress rotated and the resident rolled out of bed head first however her head was not hit as he held the residents feet. He then let go of the resident's feet and the resident laid her head on the floor however the resident complained of pain. The staff member then ran down the hall and requested assistance. During an interview 10/5/18 at 11:20 a.m., Staff K, CNA indicated as she left a resident's room on the 400 hallway she met Staff J who informed her the resident had fallen. They then yelled for Staff L, Licensed Practical Nurse (LPN) and Staff M, LPN for assistance. he staff members responded right away and assessed the resident who complained her leg and hand hurt. When Staff K asked Staff J what happened he told her he proved cares for the resident with the side rail up. He then went to the other side of the bed while the rail remained up. He continued cares and because the mattress had been slippery she fell out of the bed as he tried to catch the resident.	F 689	**Monitor for permanent solutions:** The QA Nurse and/or designee will conduct random audits to ensure the correct use and positioning of patient assistive devices while the resident is in bed, for the next 60 days to ensure compliance. All concerns will be immediately addressed. Findings will be reviewed and discussed at the monthly QAPI meeting for resolution.	

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F 689	Continued From page 6 The staff member confirmed Staff J should have had the rail down for the resident's protection. During an interview 10/5/18 at 11:36 a.m., Staff L stated as he walked down the hallway he observed Staff J frantically waving for assistance while standing 1/2 in and 1/2 out of the resident's room door. He responded and found the resident positioned on the floor beside the bed. The staff assessed the resident and found no signs and symptoms of injury and the resident failed to complain of pain. The staff member confirmed the side rail on the resident's bed as not in the correct position to maintain the resident's safety. During an interview 10/5/18 at 12:15 p.m., Staff M, stated staff alerted her of the resident's fall as she was in the parking lot of the facility. The staff member re-entered the facility and assessed the situation. The staff member performed a head to toe assessment and found no injuries not had the resident complained of pain. Staff J informed her as he tried to roll the resident he went to the other side of the bed for placement of the Hoyer sling device and the resident got away from him. Staff M could not recall the position of the side rail device. The staff member indicated later the resident complained of a head ache and because she had been on call staff informed her of the situation and she gave them the directive to send her to hospital at which time the hospital staff identified the fractured pinky finger. Staff M confirmed the side rail should have been down and/or parallel to the bed.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff.	F 725		

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F 725	Continued From page 7 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 at §483.70(e). §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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §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. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, resident council minutes and review of the facilities call light print out form the facility staff failed answer resident call lights in a timely manner (no longer than 15 minutes) for 5 of 5 residents reviewed . (Resident #1, #2, #3 #5 and #6). The facility identified a census of 82 residents. Findings include: 1. A Minimum Data Set (MDS) assessment form	F 725	**F725** **Correct to the individual:** R #1, R#2, R#3, #5 and R #6 plan of care was reviewed on 10/18/18. **Protect residents in similar situation:** Nursing Staff re-educated on the standard of care of answering call lights timely and the importance of maintaining resident dignity on 10/18/18. The Facility Self Assessment was reviewed and revised on 10/18/2018.	

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F 725	Continued From page 8 dated 9/18/18; Resident #1 had diagnosis that included respiratory failure, tracheostomy, quadriplegia, Parkinson's disease, diabetes mellitus (DM) and contractures. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) (measures cognitive status) score off 13 out 15, non-ambulatory, dependent on 2 staff with bed mobility, transfers, locomotion, personal hygiene, dressing and toilet use. The assessment indicated the resident as short of breath with exertion, sitting at rest and when laid flat. A Care Plan with a focus area dated 4/26/18 indicated the resident had an activities of daily living (ADL's) self-care deficit related (r/t) limited mobility (dated 4/26/18) and a communication deficit r/t a tracheostomy (dated 9/14/18). The interventions included the following: a. Totally dependent with bed mobility, repositioning, dressing, personal hygiene and transfers. b. Call light in reach. Review of the facilities call light response time from 9/21/18 thru 9/27/18 revealed the resident's call light on as documented below: a. 9/21/18 at 4:33 a.m. for 31.05 minutes. b. 9/24/18 at 8:49 p.m. for 22:20 minutes. 2. A MDS assessment form dated 8/17/18 indicated Resident #2 had diagnosis that included quadriplegia, hereditary and idiopathic neuropathies, pressure ulcer of the sacral region and buttock stage unidentified, weakness and a tracheostomy. The assessment indicated the resident had a BIMS score of 15, as dependent	F 725	**Measure/system prevents re-occurrence:** The facility makes every effort to hire, retain, and recruit quality staff, based on individual qualifications, certifications, license, and resident needs and personal dignity. The facility has an above average CMS Staffing Star Rating. The facility has been "Agency Free" for more than two years due to our culture of accountability, compassion, and respect for all residents, family members, and team members. The facility also retains a staffing coordinator and management on-call system to help staff find their own replacements and/or cover a shift in the event of a call-in. The facility's reinforces the standard of care that call-lights will be answered in 15 minutes or less. In the event of an outlier situation of a resident's call light not being answered or turned off within 15 minutes or less, the facility has a system in place to assess, self-identify, monitor, and address each situation for resolution.	

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F 725	Continued From page 9 on staff with ADL's, with occasional pain rated at mild and with ROM exercises every day (QD). A Care Plan revealed focus areas as dated. A self-care deficit r/t quadriplegia and debility and need for assistance with ADL's and transfers (not rated), chronic pain r/t quadriplegia status, neuropathy and chronic obstructive pulmonary disease (COPD) dated 8/17/18, current pressures ulcers r/t a history of chronic wounds, chronic skin breakdown, quadriplegia, daily wheel chair use, unable to reposition self and COPD (dated 8/17/18), a potential for infection r/t trach status and a supra public catheter and a potential for altered respiratory status/difficulty breathing r/t trach status and inability to clear respiratory secretions. The approaches included the following: a. Suctioning as needed. Review of the facilities call light response time from 9/21/18 thru 9/27/18 revealed the resident's call light on as documented below: a. 9/21/18 at 6:39 a.m. for 83:58 minutes, 6:13 p.m. for 27:42 minutes, 9:39 p.m. for 20.12 minutes. b. 9/22 at 4:17 p.m. for 28:40 minutes, 5:28 p.m. for 50:43 minutes, 9:27 p.m. for 17:06 minutes, 9:50 p.m. for 54:25 minutes. c. 9/23 at 12:25 a.m. for 19:33 minutes, 7:21 a.m. for 40:26 minutes, 8:24 a.m. for 16:26 minutes, 10:25 a.m. for 19:12 minutes, 2:17 p.m. for 20:35 minutes. d. 9/24 at 7:50 a.m. for 16:18 minutes, 9:59 a.m. for 25:20 minutes, 4:31 p.m. for 28:05 minutes. e. 9/25 at 7:33 a.m. for 29:50 minutes. 10:22	F 725	**Monitor for permanent solutions:** The Director of Nursing and/or designee will conduct daily and random audits for the next 60 days to ensure call lights are being answered timely, as well, resident dignity remains intact . Any concerns will be immediately addressed. Findings will be reviewed and discussed at the monthly QAPI meeting for resolution.	

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F 725	Continued From page 10 a.m. for 19:51 minutes, 5:19 p.m. for 19:32 minutes. f. 9/26 at 7:49 a.m. for 18:51 minutes, 5:56 p.m. for 17:52 minutes. g. 9/27 at 6:12 p.m. for 65:59 minutes and 9:34 p.m. for 41:03 minutes. During an interview 9/28/18 @ 10:36 a.m. the resident indicated on 9/27/18 he timed hi call light on approximately from 6:15 p.m. until 7:20 p.m. and at 9:15 p.m. until 10:15 p.m. at which time he wanted range of motion exercises and it made him pissed to have waited so long. The resident stated he used the only clock in his room to call light, the clock on his wall. 3. A MDS assessment form dated 7/6/18 indicated Resident #3 had diagnosis that included non-Alzheimer's dementia, insomnia and DM. The assessment indicated the resident had a BIMS score of 7, required limited assistance of staff with ambulation, locomotion, dressing, toilet use and personal hygiene. The assessment indicated the resident with one fall and no injury. A Care Plan indicated the resident had the following focus areas as dated: Impaired cognitive function/dementia or impaired thought processes r/t dementia (dated 3/19/18), the resident had an actual fall at home with no injury r/t poor balance (dated 4/3/18) and functional bladder incontinence r/t confusion and impaired mobility. a. Pressure alarm to wheel chair (dated 10/2/18). b. Pressure alarm to bed (dated 9/17/18).	F 725		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 11 Review of the facilities call light response time from 9/21/18 thru 9/27/18 revealed the resident's call light on as documented below: a. 9/23 at 9:54 p.m. for 16:00 minutes. 4. A MDS assessment form dated 9/14/18 indicated Resident #5 had diagnosis that included morbid obesity, lymphedema, gastroparesis, cellulitis, DM, stiffness of a joint, muscle weakness, pain and dyspnea. The assessment indicated the resident had a BIMS score of 15, dependent on staff with most ADL's, non-ambulatory, shortness of breath with exertion, at rest and lying flat. The assessment indicated the resident as on oxygen therapy, tracheostomy care and suctioning. A Care Plan with a focus area dated 8/14/17 indicated the resident had ADL self-care performance deficit r/t obesity, chronic obstructive pulmonary disease and arthritis and a tracheostomy r/t chronic respiratory failure. The interventions included the following: a. Suction as necessary. Review of the facilities call light response time from 9/20/18 thru 9/27/18 revealed the resident's call light on as documented below: a. 9/23/18 at 10:59 a.m. for 27:53 minutes. During an interview 10/3/18 at 10:20 a.m. the resident indicated call light response times depended on the day, what went on and the amount of staff call offs. 5. A MDS assessment form dated 10/1/18	F 725		

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	165273	A. BUILDING _____ B. WING _____	C 10/05/2018

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F 725	Continued From page 12 indicated Resident #6 had diagnosis that included morbid obesity, obstructive sleep apnea, COPD, respiratory failure, chronic pain syndrome, muscle weakness. The assessment indicated the resident had a BIMS score of 15, dependent on staff with bed mobility, transfers and toilet use and non-ambulatory. The assessment indicated the resident required tracheostomy care, a ventilator, oxygen therapy and suctioning. A Care Plan with a focus area dated 5/7/17 indicated the resident had ineffective breathing pattern r/t respiratory failure and COPD as evidence by a trach with oxygen therapy. The interventions included: a. Suction PRN. Review of the facilities call light response time from 9/18/18 thru 9/27/18 revealed the resident's call light on as documented below: a. 9/19/18 at 6:35 a.m. for 17:57 minutes, 9:12 a.m. for 18:31 minutes 6:13 p.m. 30:52 minutes. b. 9/20/18 at 10:41 p.m. for 15:51 minutes. c. 9/23/18 at 11:14 a.m. - 15:19 minutes, 6:22 p.m. for 33:06 minutes. d. 9/24/18 at 5:59 p.m. for 18:26 minutes, 6:28 p.m. for 17:15 minutes. e. 9/25/18 at 9:44 p.m. for 18:22 minutes. f. 9/26/18 at 5:08 p.m. for 55:59 minutes, 6:54 p.m. for 15:21 minutes. g. 9/27/18 at 6:29 p.m. for 17:11 minutes. During an interview 10/4/18 at 4:30 p.m. the resident stated her call light as close to 1 hour which made her feel pissed and sometimes scared and like she had been suffocating because she could not breath and required	F 725		

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F 725	Continued From page 13 suctioning. The resident also offered there had been times staff came into the room and shut off the call light, said they would return but failed to follow through so the resident put the call light right back on. During an interview 10/4/18 at 4:30 p.m. the resident indicated the facility staff failed to answer her call light within 15 minutes and there were times the call light remained on for close to or up to 1 hour. Waiting made the resident pissed and at times she felt scared because she could not breathe and felt like she was suffocating because she needed to be suctioned. The resident also indicated some staff came into her room, shut off the call light and left so she put the call light right back on. 6. During an interview 9/27/18 at 3:53 p.m., Staff E, CNA indicated staff failed to answer resident call light within 15 minutes at all times which caused the residents anger and failed to reposition resident according to their needs and/or care plan as it depended on the staffing levels. During an interview 9/27/18 at 4:03 p.m., Staff F, RN indicated staff failed to answer resident call lights within 15 minutes at all times but denied a negative outcome. During an interview 9/27/18 at 3:41 p.m., Staff G, CNA indicated she felt staff failed to perform resident rounds according to their individual needs as when she worked the 6 a.m. to 2 p.m. shift and began morning rounds/cares she found residents saturated with urine which contained a dark dried yell ring around the wet soiled portion (significant of dried urine) and odorous.	F 725		

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F 725	Continued From page 14 During an interview 9/27/18 at 4:14 p.m., Staff C, CNA indicated staff had been unable to reposition residents according to their individual needs at times to some resident's level of care. The staff member also confirmed staff as unable to answer resident call lights within 15 minutes if the facility encountered staff call offs. During an interview 9/27/18 at 4:11 p.m., Staff H, CNA confirmed that sometimes staff had been unable to answer resident call lights within 15 minutes but denied a negative outcome. During an interview 9/26/18 at 2:37 p.m., Staff I, RN confirmed residents complained that staff failed to provide rounds according to their individual needs especially on the night shift. The staff member also confirmed staff failed to answer resident call lights within 15 minutes as there had been residents that required 3 staff assistance with cares which left limited staff availability on the floor however there had been no negative outcome.	F 725		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-Identifiable Information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842	**F842** **Correct to the individual:** R #1, R#2, R#4 and R #5 plan of care was reviewed on 10/18/18. **Protect residents in similar situation:** Nursing Staff re-educated on the importance of documentation/medical records and need for proof that cares, treatments, and/or services were delivered from 10/12/18 to 10/18/18.	

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F 842	Continued From page 15 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches	F 842	**Measure/system prevents re-occurrence:** The facility does maintain and protects medical records-identifiable information in accordance with professional standards. The facility makes every effort to ensure each resident's medical record is complete, accurate, readily accessible, and systematically organized. The ADON and/or designee will conduct frequent "station checks" during the work week to monitor and ensure resident's MARS/TARs are complete and accurate. **Monitor for permanent solutions:** The QA Nurse and/or designee will conduct weekly audits for the next 60 days to ensure MARS/TARS are complete and accurate, as well as, being monitored. Any concerns will be immediately addressed. Findings will be reviewed and discussed at the monthly QAPI meeting for resolution.	

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F 842	Continued From page 16 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to completely and accurately document in 4 of 4 resident's medical record. (Resident #1, #2 , #4 and #5) The facility identified a census of 82 residents. Findings include: 1. A Treatment Administration Record (TAR) form for July, 2018 indicated Resident #1 had diagnosis that included Parkinson's Disease, Respiratory Failure, Cervical Fusion, Cervical Fracture and Quadriplegia. According to the TAR the facility staff failed to perform the following treatments as dated: a. Skin Prep to bilateral heels and the right shin 2 times a day (BID) dated 5/16/18 - No treatment performed on the 6 p.m. to 6 a.m. shift on the 10th and 19th. b. Trach cares BID and as needed (PRN) dated 5/8/18 - on the 6 a.m. to 6 p.m. shift dated	F 842		

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F 842	Continued From page 17 the 28th thru the 30th. and on the 6 p.m. to 6 a.m. shift on the 7th. c. Cleanse and replace the inner cannula daily and PRN dated 5/8/18 - on the 28th thru the 30th. d. Check skin daily dated 5/31/18 - the 2nd thru the 9th, 11th, 12th, 14th thru the 16th, 19th, 20th ad the 27th thru the 30th. e. Do not let the water bottle run dry for humidity dated 5/31/18 (related to the trach) - On the 6 a.m. to 6 p.m. shift from the 1st thru the 9th, 11th and 12th, 14th thru the 16th, 19th and 20th. On the 6 p.m. thru 6 a.m. from the 1st thru the 8th and the 22nd. f. Elevate the right upper extremity on 2 pillows for dependent edema dated 5/31/18 - On the 6 a.m. to 6 p.m. shift from the 1st thru the 9th, 14th and 19th. On the 6 p.m. until 6 a.m. from the 1st thru the 8th. g. Cleanse the buttocks/coccyx area and apply A&D ointment and stoma powder mixture BID and PRN (not dated however the 1st staff initials appeared on the 2nd and the treatment had been discontinued on the 11th) - on the 6 a.m. to 6 p.m. shift on the 7th and 8th and the 6 p.m. to 6 a.m. shift on the 7th. h. Mix Calmoseptine and Stoma powder apply to buttocks BID and PRN until healed (not dated but started on the 11th) - The 6 a.m. to 6 p.m. shift on the 14th, 19th and 23rd. i. Betadine paint to lateral left foot BID (not dated but started on the 11th. - The 6 a.m. until 6	F 842		

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F 842	Continued From page 18 p.m. shift on the 14th and 19th. 2. A TAR form for August 2018 indicated Resident #2 had diagnosis that included Pressure Ulcers, Arterial Dissection, Autonomic Dysreflexia, Pruritis, Neuropathy and Muscle Spasms. According to the TAR form the facility staff failed to perform the following treatments as dated: a. Cleanse wound at the right an left ischial at the scrotum with saline. Apply a small piece of Maxorb. Re-apply every other day and PRN dated 8/28/17 - The 21st and 27th. b. Ketoconazole cream 2% to rash on posterior buttocks with dressing change as directed dated 10/26/17 - The 21st an 27th. c. Maxorb Extra apply to wounds with small amount of silver as directed dated 10/26/17 - The 21st and 27th. d. Petroleum gel apply to right anterior thigh and scrotum as directed dated 10/26/17 - The 21st and 27th. e. Acetic Acid solution 0.25 % irrigate with 60 milliliters (ML) BID as directed dated 1/7/18 - The 6 a.m. to 6 p.m. shift on the 20th and 21st. The 6 p.m. to 6 a.m. shift on the 2nd, 3rd, 17th thru the 19th and the 31st. f. Maxorb Extra AG+ 4 inches (") x 4 (") - 0.75 " use as directed dated 5/24/18 - The 21st and 27th. g. Aquacel AG pad 4" x 5" use as directed dated 6/19/18 - The 21st and 27th.	F 842		

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F 842	Continued From page 19 h. Float elbows and heels with pillows BID dated 7/5/17 - The 6 a.m. to 6 p.m. shift on the 3rd, 6th, 7th, 12th, 13th, 20th, 21st 24th thru the 26th. The 6 p.m. to 6 a.m. shift on the 3rd, 18th, 30th and 31st. i. Skin check daily (no tape over donor sites) dated 7/5/17 - The 3rd, 6th, 7th, 12th, 13th, 20th, 21st, 24th thru the 27th. j. Cleanse supra pubic catheter with water cover with split 2 x 2 QD, calcium alginate to an open area PRN dated 7/5/18 - The 3rd, 6th, 12th, 13th, 20th, 21st, 24th thru the 27th. k. Range of motion (ROM) at bedtime dated 7/5/18 - The 2nd, 3rd, 9th, 10th, 16th thru 18th, 23rd thru the 25th 30th and 31st. l. Pronation splint for left upper extremity in place 1-5 hours at a time BID dated 7/5/17 - On the 6 a.m. to 6 p.m. shift the 3rd, 12th, 13th, 20th, 21st and 24th thru the 26th. On the 6 p.m. to the 6 a.m. shift on the the 2nd 3rd, 18th, 25th, 30th and 31st. m. Heel lift boots to bilateral lower extremities at all times, may remove for cares and transfers dated 7/5/17 - The 6 a.m. to 6 p.m. shift on the 3rd, 6th, 12th, 13th, 20th, 21st and 24th thru the 26th. The 6 p.m. to the 6 a.m. on the 3rd, 18th, 25th and 31st. n. Vaseline or a similar product to scrotum/donor sites 3-4 x's a day dated 7/5/17: a. HS - 2nd thru the 4th, 18th and 31st. b. am, noon, evening - 6th, 12th, 13th, 20th, 21st and the 24th thru the 27th.	F 842		

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F 842	Continued From page 20 c. noon, evening - 7th and 11th. d. noon, evening and HS - 30th. d. am, noon, evening and HS - 3rd. 3. A MDS assessment form dated 7/10/18 indicated Resident #4 had diagnosis that included cerebral palsy, DM, arthritis, osteoporosis, depression, unspecified intellectual disabilities, contractures and muscle weakness. According to the TAR form dated July 2018 the facility failed to provide the following treatments as dated: a. Application of Vitamin A&D ointment topically to the buttock/peri area with peri cares every shift, application of Muscle Rub cream to the right calf and bilateral shoulders every shift and - The 6 p.m. to 6 a.m. shift the 15th, 19th and 26th. b. Application of Cetaphil Lotion Moisture Cream every night at HS - 8th, 15th, 19th and 26th. c. Application of Mepilex 4 x 4 to open areas on the coccyx and left buttocks daily - 8th, 10th, 11th and 13th. 4. A MDS assessment form dated 9/14/18 indicated Resident #5 had diagnosis that included morbid obesity, lymphedema, gastroparesis, cellulite's, DM, stiffness of a joint, muscle weakness, pain and dyspnea. A TAR form dated October 2018 indicated the staff failed to perform the following treatments on 10/1/18 on the 6 p.m. to 6 a.m. shift: a. Cleanse the areas on the residents left gluteal crease and right buttock followed by an	F 842		

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F 842	Continued From page 21 application of Desitin cream every shift and PRN. b. Cleanse the right heal followed by an application of Skin Prep BID. c. Cleanse the area on the right abdominal fold followed by an application of stoma powder every shift and PRN.	F 842		