STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165548	A. BUILDING _____ B. WING _____	10/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR SPRINGS OF WEST DES MOINES L L C	7951 E P TRUE PARKWAY WEST DES MOINES, IA 50266

(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 11/9/18 The following deficiencies result from the facility's annual health survey and investigation of facility reported incident #78861-I. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 582		

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

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 12/6/18 VS

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F 582	Continued From page 1 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview, the facility failed to provide timely Notice of Medicare Non-Coverage (NOMNC) (Centers for Medicare Services [CMS] form 10123) for 2 of 3 skilled residents reviewed (Residents #99 and 100) and Mandatory denial notice CMS form 10055 for 1 of 3 skilled residents reviewed (Residents # 99). The facility reported a census of 48 at the time of the survey. Findings include: Information provided by the facility on the	F 582		

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F 582	Continued From page 2 Entrance Conference Worksheet revealed the following: a. Resident #99 received skilled services at the facility from 5/11/18 through 5/15/18. b. Resident #100 received skilled services at the facility from 8/24/18 through 9/7/18. Review of the documents provided for Resident #99 titled Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) revealed the resident had not been notified in advance of the impending discharge by the facility from skilled services. Also, the facility failed notify the residents (Resident #99 and #100) of the right to have a claim submitted to Medicare and of the standard claim appeal rights that apply if the claims denied be Medicare. During an interview on 10/09/18 at 9:40 AM with the Administrator stated the Social Worker left the facility in the middle of July and a new Social Worker started on 10/ 2/18. The Administrator stated the Assistant Director of Nursing (ADON) had talked with Resident #100's family and went over both forms but failed to send form 10123 to have it signed. The Administrator further stated she doubled checked the chart for Resident #99 and they did not have any forms signed for him.	F 582		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the	F 622		

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F 622	Continued From page 3 resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified	F 622		

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F 622	Continued From page 4 in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F 622		

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F 622	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility checklist review, the facility failed to provide discharge and medical information to the receiving health care institution at the time of discharge for one of four residents reviewed who transferred to the hospital (Resident #49). The facility reported a census of 48 residents. Findings include: 1. Review of the MDS (Minimum Data Set) assessment dated 8/15/18 revealed Resident #49 had an unplanned discharge to the hospital on 8/15/18. Review of the facility's electronic medical record Census List revealed the resident discharged from the facility on 8/15/18. The physician's order dated 8/15/18 revealed an order to send the resident to the ER (Emergency Room). The progress notes revealed the following: 8/15/18 at 6:57 AM, resident sent to the hospital after a fall. 8/15/18 at 2:16 PM, resident admitted to the hospital. 8/17/18 at 8:32 PM, resident in hospital and return transfer expected possibly 8/18/18. The clinical record lacked documentation of information sent with Resident #49 when she transferred to the hospital on 8/15/18. In an interview 10/11/18 at 11:25 AM, the MDS Coordinator reported when a resident transferred	F 622		

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F 622	Continued From page 6 to the hospital, staff printed a transfer form from the electronic health record system. The MDS Coordinator reported nursing staff wrote pertinent information on the form, made a copy of the form, and sent the form to the hospital with the resident. The MDS Coordinator stated they had a checklist of items which included the tasks staff completed when a resident transferred or discharged from the facility. On 0/11/18 at 2:17 PM, the MDS Coordinator reported no transfer form found in the medical record for Resident #49. The MDS Coordinator stated the nurse had called report to the hospital when Resident #49 had transferred to the ER. The Discharge Checklist dated 3/9/18 instructed staff should complete a transfer form and make a copy for the facility's records whenever a resident discharged/transferred from the facility.	F 622		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (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. (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 (iii) Include in the notice the items described in	F 623		

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F 623	Continued From page 7 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (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. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (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 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (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 8 hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (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 (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. §483.15(c)(6) Changes to the notice. 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. §483.15(c)(8) Notice in advance of facility closure 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 9 This REQUIREMENT is not met as evidenced by: Based on clinical and facility record review and staff interview, the facility failed to notify the Long Term Care Ombudsman of resident transfers for 3 of 4 residents reviewed for hospitalization (Residents #20, #48, and #49). The facility reported a census of 48 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/28/18 for Resident #20 documented a Discharge Return Anticipated assessment. The Census List dated 10/11/18 documented the resident's status as on Hospital Paid Leave on 7/28/18. The Progress Notes dated 7/28/18 at 6:23 p.m. documented the resident admitted to the hospital for pneumonia. The Progress Notes dated 8/1/18 at 5:35 p.m. documented she returned to the facility. Review of facility records revealed a lack of documentation to show staff notified the Long Term Care (LTC) Ombudsman of the resident's transfer out of the facility. In an interview on 10/11/18 at 12:00 p.m., the Administrator reported a recent changeover occurred in the social service position. The social service person is responsible for Ombudsman notification but she could not access her email. The Administrator reported she had a call out to IT (Information Technologies) to see if they could access the emails and a call out to the Ombudsman to see if the former social service	F 623		

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F 623	Continued From page 10 person had submitted names of residents discharged or transferred out of the facility. 2. The MDS assessment dated 8/15/18 for Resident #48 documented a Discharge Return Anticipated assessment. The resident's electronic chart listed the resident status as Hospital Paid Leave on 8/15/18. The Progress Notes dated 8/15/18 at 4:19 p.m. documented the resident admitted to the hospital with sepsis (infection). The Progress Notes dated 8/31/18 at 3:00 p.m. documented the resident returned to the facility. Review of facility records revealed no documentation to show staff notified the LTC Ombudsman of the resident's transfer out of the facility. 3. Review of the MDS assessment dated 8/15/18 revealed Resident #49 had an unplanned discharge to the hospital on 8/15/18. The clinical record lacked documentation of notice to the LTC Ombudsman that Resident #49 discharged to the hospital as required by federal regulation. In an interview on 10/11/18 at 11:50 AM, the Administrator reported she found a list of residents discharged or transferred from the facility and their destination, but she did not know if the former social worker sent notice to the LTC Ombudsman.	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		

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F 625	Continued From page 11 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident representative interview, staff interview, and facility record review, the facility failed to provide a copy of the bed hold policy at the time of transfer to the hospital for 3 of 4 residents who required bed hold notification (Residents #20, #48, and #49). The facility reported a census of 48 residents.	F 625		

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F 625	Continued From page 12 Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/28/18 for Resident #20 documented a Discharge Return Anticipated assessment. The Census List dated 10/11/18 documented the resident's status as on Hospital Paid Leave on 7/28/18. The Progress Notes dated 7/28/18 at 6:23 p.m. documented the resident admitted to the hospital for pneumonia. The Progress Notes dated 8/1/18 at 5:35 p.m. documented she returned to the facility. The clinical record lacked documentation the resident or resident representative received a bed hold notice at the time of transfer on 7/28/18. In an interview on 10/8/18 at 11:31 a.m., Resident #20's son reported Resident #20 had been hospitalized a few months back for pneumonia. Resident #20's son did not recall getting the notice of bed hold, he just remembered getting the discount for coming back on Medicare which covered part of her cost of stay. In an interview on 10/11/18 at 12:00 p.m., the Administrator stated the Assistant Director of Nursing (ADON) reported the nurses documented in the nurses notes when they verbally informed families about bed hold notices. 2. The MDS assessment dated 8/15/18 for Resident #48 documented a Discharge Return Anticipated assessment. The resident's Census list dated 10/11/18	F 625		

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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 625	Continued From page 13 documented the resident's status as Hospital Paid Leave on 8/15/18. The Progress Notes dated 8/15/18 at 4:19 p.m. documented the resident admitted to the hospital with sepsis (infection). The Progress Notes dated 8/31/18 at 3:00 p.m. documented the resident returned to the facility. The clinical record lacked documentation the resident or resident representative received a bed hold notice at the time of transfer on 7/28/18. 3. Review of Resident #49's medical record revealed no documentation of notification to the resident or resident's family regarding the bed-hold policy when the resident transferred to the hospital on 8/15/18. In an interview 10/11/18 at 11:35 AM, the Assistant Director of Nursing (ADON) reported she expected the nurse who transferred the resident to the hospital to notify the resident or representative about bed hold policy. The ADON reported if an agency nurse worked, she followed up and spoke to the resident or representative about the bed hold. The ADON acknowledged they had no documentation in the resident's record about the verbal conversation they had with the resident or representative about the bed hold policy.	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For	F 637		

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F 637	Continued From page 14 purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on clinical recorded review and staff interviews, the facility failed to complete a significant change assessment after discharge from Hospice care for 1 of 3 residents reviewed for Hospice care (Resident #15). The facility reported a census of 48. Findings include; The quarterly Minimum Data Set (MDS) assessment dated 7/17/18 for Resident #15 documented diagnoses that included osteoporosis, high blood pressure, Non-Alzheimer's dementia and chronic lung disease. The resident required the assistance of one staff for bed mobility, dressing and personal hygiene and the assistance of two staff for transfers and toilet use. The MDS reported a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating severe cognitive and memory impairment. The assessment recorded Resident #15 received Hospice care while residing in the facility. The significant change MDS assessment dated 9/24/18 for Resident #15 documented diagnoses that included osteoporosis, high blood pressure, Non-Alzheimer's dementia and chronic lung	F 637		

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F 637	Continued From page 15 disease. The resident continued to require the assistance of one staff for bed mobility, dressing and personal hygiene and the assistance of two staff for transfers and toilet use. The MDS reported a BIMS score of 5 out of 15 indicating severe memory and cognitive impairment. The resident continued to receive Hospice care. Resident #15's care plan dated 7/26/18 contained a topic of Extra Things to Know which documented the resident was served by Hospice of Central Iowa (HCI). The resident's Census List dated 10/11/18 documented that Hospice Care changed to private pay on 8/5/18. A Progress Note dated 8/10/18 at 8:50 AM recorded the Hospice Nurse stated the resident discharged from Hospice on 8/5/18 at midnight. During an interview on 10/10/18 at 2:34 PM with the Assistant Director of Nursing (ADON) acknowledged the facility did not do a significant change MDS assessment when Resident #15 changed from Hospice back to private pay.	F 637		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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.	F 684		

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F 684	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and interviews, the facility failed to assess and continue skin treatments for one of two residents reviewed for skin issues (Resident #15). The facility reported a census of 48. Findings include: The MDS (Minimum Data Set) assessment dated 7/17/18 for Resident #15 documented diagnoses that included osteoporosis, high blood pressure, Non-Alzheimer's dementia and chronic lung disease. The resident required the assistance of one staff for bed mobility, dressing and personal hygiene and the assistance of two staff for transfers and toilet use. The MDS reported a BIMS score of 6 out of 15 indicating severe memory and cognitive impairment. The assessment also documented Resident #15 had the risk of pressure ulcer development, but had no ulcers at the time of the assessment. Resident #15 Care Plan dated 7/26/18 recorded Resident #15 wore geri sleeves /long sleeves at all times on both arms along with Dermasavers to her legs (to protect the skin). The physician notification fax dated 9/15/18 reported Resident #15 received 2 inverted "V" shaped skin tears below the right knee when transferred into the wheelchair while she wore thick leg protectors. Staff noted dried blood when they removed the leg protectors at nighttime. Staff covered the skin tears with Bacitracin (an antibiotic ointment) and applied Telpha and Kling dressings; the physician approved this treatment.	F 684		

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F 684	Continued From page 17 The Phone Order dated 9/15/18 ordered staff to apply Bacitracin Ointment 500 units/gram to the left leg below the knee every evening shift for the skin tear. Cleanse with normal saline and cover with Telpha and Kling dressing until healed. Two staff noted the order, which identified treatment to the left leg instead of the injuries on the right leg. The resident's Skin Condition Report for Non-Pressure Sore Skin Conditions for the right distal wound documented the following: a. On 9/15/18 the wound distal to knee measured 1 centimeter (cm) by 1 cm with dried blood removed, warm to touch and an initial treatment of Bacitracin. b. On 9/19/18, the wound measured 1.0 cm and showed healing progress. c. On 10/8/18, the wound measured 1.0 cm with dry and intact steri strips and good (healing) progress. The Skin Condition Report for Non-Pressure Sore Skin Conditions for the right lateral wound documented the following: a. On 9/15/18, the wound measured 1 cm by 1 cm with an initial treatment of Bacitracin. b. On 9/19/18, the wound measured 1.0 cm and appeared bluish-purple in color and with progress. c. On 10/8/18, the wound measured 1.0 cm with dry/intact steri strips and good progress. The resident's Treatment Administration Record (TAR) for September 2018 recorded Bacitracin ointment application to the left leg below the knee topically every evening shift for a skin tear; cleanse with normal saline, cover with Telpha and Kling until healed with a start date of 9/15/18 and	F 684		

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F 684	Continued From page 18 discontinuation date of 9/21/18. The 9/21/18 entry also documented the number 9. The September 2018 TAR also included a nursing order for weekly skin checks. If staff noted areas of concern, they should fill out a skin assessment as well every Wednesday. The TAR lacked documentation of a weekly skin check on Wednesday 9/12/18. The October 2018 TAR continued to documented the nursing order for weekly skin checks and if staff noted areas of concern, they should fill out a skin assessment as well every Wednesday. The TAR lacked a weekly skin check on Wednesday 10/3/18. During an observation on 10/08/18 at 10:21 AM, Resident # 15 wore Dermasavers on both legs and geri sleeves on both arms. The observation revealed a steri strip to Resident # 15's right leg below her knee. During an observation on 10/10/18 at 11:27 AM Staff O Certified Nursing Aide (CNA) lifted the resident's pant leg and pulled down the Dermasaver on the right leg, revealing steri strips or tape to right leg below the knee. On 10/10/18 at 2:34 PM, the Assistant Director of Nursing (ADON) stated the facility did not need an order to discontinue the treatment if the original order said until healed. The TAR for 9/21/18 listed # 9 for the last day the treatment done which indicates a progress note. The ADON reviewed the progress notes and could not locate a progress note dated 9/21/18. The TAR lacked documentation for the weekly skin assessment done 10/3/18. The ADON	F 684		

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F 684	Continued From page 19 acknowledged she did not know why they discontinued the treatment if the area was not healed. She would expect the nurses to document on the skin sheet weekly along with doing weekly skin assessments.	F 684		
F 689 SS=J	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 clinical record review, observation, staff interview, and facility record review, the facility failed to develop a systemic approach to lock exterior courtyard gates to ensure gates locked at all times for 1 of 3 residents reviewed for wandering/elopement (Resident #17). The facility reported a census of 48 residents. Findings include: The Minimum Data Set (MDS) assessment dated 7/17/18 for Resident #17 identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The MDS documented diagnoses that included Non-Alzheimer's dementia, anxiety disorder, depression, insomnia, and chronic pain. The MDS recorded no behavioral symptoms present during the 7 day assessment reference period. The resident displayed independence with bed	F 689		

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F 689	Continued From page 20 mobility, transfers, walking in the room and corridor, and locomotion on the unit. The Plan of Care dated 7/26/18 identified the following: a. Specific Behaviors - at times the resident may ask to be let off the neighborhood on 2-10 (p.m./afternoon shift). The resident may be exit seeking, or ask to go upstairs. b. Extra Things to Know - the resident had an elopement risk and his picture is on the elopement risk poster. d. Bed and Mobility Devices - the resident may be up overnight when exit seeking, pounding on exit doors 2-10/10-6 (evening and overnight shifts). e. Transfers and Ambulation - the resident is independent in transfers and ambulation; supervise with ambulation in the hallway; and on 9/1/18, 15 minute checks. The poster titled Residents at Risk for Elopement dated 7/6/18 included a picture of Resident #17 with his room number. The Elopement Risk Tool dated 7/26/18 identified Resident #17 as at risk for elopement. The Progress Notes dated 8/1/18 at 9:56 p.m. documented the resident as restless and anxious at 3:00 p.m. The note recorded the resident asked for his anxiety meds, as not exit seeking, and less agitated and more easily redirected than the day before on 2-10. The Progress Notes dated 8/2/18 at 7:32 p.m. documented the resident exhibited minor exit seeking behaviors in the early afternoon and he wandered on and off most of the evening.	F 689		

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F 689	Continued From page 21 The Progress Notes dated 9/1/18 at 5:50 p.m. documented the CNA (Certified Nurse Aide) reported Resident #17 exited the courtyard gate when she assisted other residents to return from the courtyard. The resident returned immediately and safely from the parking lot. Staff notified the resident's daughter, the Administrator, and doctor via phone. At 7:00 p.m. staff documented checking on Resident #17 every 15 minutes and the resident appeared agitated and sought to exit the facility after talking to his brother on the phone. Resident #17 asked for his car keys so he could drive home. Staff attempted redirection unsuccessfully, turned the TV to the baseball game for distraction, and gave him a non-alcoholic beer. The Progress Notes dated 9/2/18 at 9:15 p.m. documented at 8:15 p.m. the resident requested to go out and find his bike to ride to his car; the resident wanted to see his mother and father. The nurse documented distracting him with stories of the heavy rains. The note documented at 8:50 p.m. the resident continued to request to go outside, staff offered a cup of water and a cookie, then the resident fell asleep in the chair. The facility identified a census of 9 residents on 9/1/18 who resided on the Maple neighborhood and indicated 5 of those residents as self mobile (Resident #26, Resident #13, Resident #3, Resident #27, and Resident #17). Review of the Shift Assignments dated 9/1/18 identified the following staff assigned to the Maple unit where Resident #17 resided: Staff G, CNA and Staff F, CNA, for the 6 a.m. to the 2 p.m. shift Staff D, CNA, and Staff E, CNA for the 2 p.m. to	F 689		

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F 689	Continued From page 22 10 p.m. shift. Staff C, Registered Nurse (RN) for the 2 p.m. to 10 p.m. shift The undated, signed, written statement by Staff E contained a fax stamp of 10/1/18 at 1:45 p.m. Staff E wrote the following: Staff E pool staff assisted residents out of the dining room after dinner. Staff E's co-worker decided to open the patio door for residents that wanted to get some fresh air outdoors. Then Staff E's co-worker told her to watch the residents in the commons (TV) area while Staff D watched the residents outside on the patio. Resident #17 was one of the first residents to take advantage of the patio experience and the last time Staff E saw him at that particular time was after dinner with Staff D on the patio. The undated, unsigned, written statement by Staff D contained a fax stamp of 10/1/18 at 1:45 p.m. Staff D wrote the following: After dinner around 5:40 p.m. Staff D took Resident #3, Resident #17, and Resident #48 outside into the courtyard. They were outside for only a few minutes when Resident #3 went back inside with Resident #17, Resident #48, and Staff D still outside. Staff D called to her partner to come help stand Resident #48 up so she could shake off crumbs from his clothing; Resident #17 stood right next to them. At that point, Resident #27 walked into the dining room and sat on the arm of the chair, which was wobbly. Staff D's partner couldn't get him to sit down properly so she assisted her in sitting him down. Staff D went back out, brought Resident #48 into the living room, right after that Staff D went out to her car. On Staff D's way out, Resident #26's daughter then walked Resident #17 back in. Staff D went out to her car around	F 689		

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F 689	Continued From page 23 5:50 p.m. Staff D believed Resident #17 got out while she assisted her partner with Resident #27 (it only took 2 minutes with Resident #27). Staff D thought Resident #17 got out through the courtyard gate because it was not locked. Usually the first thing Staff D did after getting report would be to always check iPods, iPad, and gate, and if they checked the courtyard cameras they would see her checking gates. When Staff D started her shift that day it was very hectic between Resident #37 and Resident #17 being anxious, Resident #48 having visitors, and having an agency aide. Staff D got distracted and didn't fill out her shift sheet which meant she didn't check the gate. Observation on 10/8/18 at 11:53 a.m. revealed Resident #17 stood up from a straight back chair independently and Staff A, CNA, redirected him from the doorways. At 12:24 p.m. Resident #17 wandered out of the dining room and informed staff he was looking for the outside. Staff T, Certified Medication Aide (CMA), redirected Resident #17 and told him they had his lunch ready first. Resident #17 could not exit the main neighborhood doors when he attempted to push on them as the doors were locked with the keypad code required to exit the neighborhood. Observation on 10/8/18 at 3:04 p.m. revealed Staff B, Licensed Practical Nurse (LPN), demonstrated how the Maple unit courtyard gate locked. Staff B reported the gate must be unlocked by a key and then they push the button for a latch to unhook to be able to open the door. Observation on 10/10/18 at 7:47 a.m. revealed Resident #17 attempted to get into the locked dining room. Resident # 17 asked Staff A to	F 689		

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F 689	Continued From page 24	F 689		

unlock the door, she did, and staff were present in the dining room with the patio doors locked. Resident #17 went straight to the table and sat down to drink.

In an interview on 10/08/18 at 1:50 p.m., Staff C recalled working on 9/1/18 when Resident #17 eloped. Staff C stated after dinner Staff D had several residents out in the courtyard that day. Staff C reported Staff D turned to push one of the wheelchairs into the dining room and one of the other residents started to sit on the arm of a chair. Staff D turned to help that resident with the chair and when she stepped back through the door she didn't see Resident #17, so she thought she missed him coming back in. Staff C stated Staff D knew that Resident #17 went outside (to the courtyard). Staff C reported another CNA, Staff E, took other residents from the dining room to the commons area while she was in the nurses station. Staff C received notice that Resident #17 had been out of the facility when Staff D told her he had gotten out and she saw him coming back into Maple unit. Staff C completed an assessment and the resident had no injuries. Resident #17 stated he was looking for his car, this was a common theme for the resident and at night time he wanted to look for his car. Usually if Resident #17 wanted to go out, they went out with him to the courtyard, he would see no cars, and then go back inside. Staff C had never heard of any difficulty getting him back inside or of any other elopements. Staff C said the CNAs had keys for the gates, they are supposed to check at the beginning of each shift, and sign off the gate check on paper. Staff C said she did not talk to the family member who found Resident #17 outside the building and Staff D reported the family member as the daughter of a different

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F 689	Continued From page 25 resident who resided on Maple. Resident #17 did not seem upset and she thought he was only outside just a few minutes. It was a nice day with no inclement weather. Staff C called the Administrator to report immediately. Staff C thought the failure someone unlocked that gate at some point in time. Staff C stated Staff D reported the shift change chaotic that day and at shift change Staff D did not check the gate. The pool aide (CNA from temporary staffing agency) would not know, that it would be one of the facility's staff responsibility unless they had worked there a lot. Staff C had not met Staff E before so expected Staff D to check the gate. Staff D admitted to not checking the gate and felt really bad. Staff C said she immediately had all the units check their gates and do a head count as soon as she looked at Resident #17 and made sure he was okay. In an interview on 10/8/18 at 2:30 p.m. Staff F recalled she heard about the incident with Resident #17 when she got back to work the next day. Staff are supposed to check the gate when they get on the neighborhood and they had 30 minutes to complete it, so it's done on rounds. Staff F said the partner could also check. Staff F recalled being asked if they checked that morning and her partner (Staff G) said she checked the gate. Staff F responded you should check the gate by pushing on it then push a little button but you have to have the key to unlock it. If it's unlocked, you push down on the button to push open. Staff F stated she documented the checks on the shift change sheets with her initials. Staff F did not know how it got unlocked. Staff F stated the Education Director trained her by having her unlock and lock the gate. Staff F had never seen the gate unlocked unless by the	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR SPRINGS OF WEST DES MOINES L L C	7951 E P TRUE PARKWAY WEST DES MOINES, IA 50266

(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 689	Continued From page 26 mower but they announce that and she did not recall the lawn being mowed that day. On 10/9/18 at 12:36 p.m., Staff D recalled working the night Resident #17 eloped. Right after supper she took Residents #17, #48, and #3 outside while her partner, Staff E, worked inside in the commons area. Resident #3 walked back in and Staff D either wheeled Resident #48 back in or was getting ready to, she couldn't recall. Staff D stated Resident #27 tried to sit on the arm of a chair in the dining room and Staff G could not redirect him, so Staff D stepped in and got Resident #27 to sit down properly. Staff D reported the entire incident all happened within 5 minutes. Staff D said she informed her partner she was going to her car to grab something. Staff D said she then saw Resident #17 in the hallway walking with one of Resident #26's daughters. Staff D stated Resident #17 had left and been found in five minutes or less; she thought he slipped out about 5:50 p.m. to 5:55 p.m. Staff D said at 5:45 p.m. they got done with supper, about 5:50 p.m. she took the residents outside, and at 5:55 p.m. Resident #17 walking back in; he did not appear upset at all or dirty. Staff D stated she asked Resident #17 where he had been and he responded just right here; she did not think Resident #17 knew what he was doing. Staff D thought it was a nice day. She reported working for the facility for 8 months, hired February 2018, and she resigned the previous month. Staff D stated Resident #17 always was exit seeking to want to go home or go upstairs but he gave no signs before it happened; he did not say he wanted to leave. Staff D commented she did not get a chance to check the gate at 2:00 p.m. The unit was hectic, chaotic, they just got new resident (#48) and he tried to climb out of	F 689		

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F 689	Continued From page 27 bed. There were 2 CNA's assigned to the unit and the Administrator present (at the beginning of the shift). Staff D got a quick report and she had Staff E with her who hadn't worked there before, so had to walk her through everything. Staff D stated she always checked the gate, it just happened that day she didn't. Staff D reported the morning shift signed the sheet as locked and the facility had no lawn care that day, so the gate had to be unlocked on the morning or overnight shift. Staff D did not see Resident #17 walk out and there would be no way he could get under the gate. Staff D confirmed the gate as unlocked when she went to check it after Resident #17 came back into the unit. Staff D thought people really were checking the gate, signing the sheet, and when she worked with her partner they always checked and signed. In a follow-up interview on 10/10/18 at 11:42 a.m., Staff D responded she did not know exactly when trained or who trained her on the gates but she knew she had received training. Staff D said after the incident she was trained to press the black button to check the lock. In an interview on 10/9/18 at 1:11 p.m. the Education Director stated the staff training reiterated not to check the gate by pulling on the door as they could pull with all their might and the door won't open due to the style of latch, but the door may still be unlocked. The Education Director stated the staff are also trained not to check with the key in the lock as it may inadvertently unlock. The facility's expectation of staff is to use the palm of their hand to push on the button style key lock and ensure the gate is locked. In an interview on 10/9/18 at 2:35 p.m. the	F 689		

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F 689	Continued From page 28	F 689		

Administrator and the Assistant Director of Nursing, (ADON) stated gates were to be checked by the facility CNA's at a minimum of 3 times a day, at the beginning of each shift. The ADON and the Administrator had reeducated staff on the proper way to check the gates, completed elopement drills, and department heads checked the gates daily at random times after the elopement. The ADON responded the staffing level as normal with 2 CNA's for the Maple unit. Staff planned Resident #17 to be supervised while outside but Staff D assisted Resident #27 from sitting on the edge of the chair as well as assisted her partner to keep Resident #27 from escalating with behaviors. The ADON felt staff chose the safety of one and turned back to the courtyard. The ADON stated there were no cues for Resident #17 to elope and it would not be normal for him to wander away from the group. Resident #17's usually went to all activities, ice cream socials, John Deere outings, and often stood outside his room located directly next to the dining room which leads to the patio. The ADON stated Resident #17 went out to the patio before and he walked independently without supervision or an assistance device. The ADON event occurred at approximately 5:50 p.m. and he was outside for approximately 5 minutes.

In an interview on 10/9/18 at 3:20 p.m., Staff G stated she worked for the facility since the beginning of the year and only worked on the Maple unit. Staff G recalled she checked the gate and she stated she did not know that gate to ever open. Staff G stated the guy she worked with the day before, Staff H CNA, double checked the door with her and said they must check it every day when doing rounds. Staff G said the first thing she did was go to lock the door. She

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F 689	Continued From page 29 used the key to unlock, lock again and then jiggled to make sure not open. Staff G said it was the first time she ever had to check the gate as she had never taken anybody outside; she worked every other weekend and didn't like to go outside as a group because Resident #17 could sundown (get confused) quickly. Resident #17 would start asking for the keys to the car and when she heard him say that, she redirected him to have a beer to try to distract him. Staff G stated that day the resident acted very calm and she expressed surprise that he went outside. They checked that gate so she thought it impossible Resident #17 exited; someone had to let him out because the gate locked. Staff G reported she gave the keys to the permanent girl. Staff G stated she received training on gates by the Education Director who covered everything and got training after the elopement too. Staff G stated the Administrator came and had her sign a paper that it's their responsibility to check, they must shake the gate to make sure it locked, and check all your residents. Staff G stated the staff just needed to keep a close eye and be observant with Resident #17. In a follow-up interview on 10/10/18 at 11:31 a.m., Staff G clarified she put the key in the door how Staff H showed her and tested to make sure the gate fully locked. Staff G said after she locked it she took the key out, pushed on the button, and shook it a little bit to make 100% sure the gate door locked. In an interview on 10/10/18 at 10:03 a.m. the Administrator reported the first 6 days in staff orientation, staff are assigned a trainer who is another CNA who went through the trainer course. The Education Director stated Staff H is not a trainer. The Education Director responded she did not think the facility had a written	F 689		

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F 689	Continued From page 30	F 689		

procedure to check the gate but she would look at the education. The Education Director stated after the incident, they facility listed the gate check as a separate line on the CNA checklist and before this incident the trainer trained the CNA's. The Education Director met with the trainers yearly as a group and small informal meetings were conducted approximately every 6 months and they had no documentation of the meetings. The Education Director confirmed Staff D as trained by Staff I, CNA, on 2/27/18 for the task sheet, also known as CNA Nurse Communication Sheet on the checklist. The Education Director stated the other place the checklist would reflect training on gates would be the change of staff and rounds which Staff R, CNA, had signed training provided to Staff D and that Staff R also a trainer. The Education Director stated the hand written gate training written on Staff D's checklist was written the night before to highlight for the surveyor where the gate locking would have been covered. The Education Director stated now after the incident, the locking the gate covered on days 1 and 2 of orientation. The Education Director stated if they found a problem, they would expect to activate their QA process and go back to retrain staff. Prior to the incident they relied on CNA's to initial on the task sheet. The Administrator said on 9/2/18 she spoke to both aides, (Staff G and Staff F) and neither put the key in the lock. The Administrator said numerous times she told them to push the button. The Administrator stated she worked on 6 to 2 shift (9/2/18) so she educated them. The Education Director stated she went out with Staff G, who said the Administrator had already retrained her, and asked her questions; she still wanted Staff G to show her how she checked the gate and she did not put the key in

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F 689	Continued From page 31	F 689		

the lock at that time. The Administrator reported Staff G had been off on maternity leave for 3 months and returned 8/19/18, so 9/1/18 would have been Staff G's second weekend to work. The Education Director thought it doubtful Staff G retrained upon return from maternity leave. The Education Director stated she trained the trainers and before the incident there were variations in how staff checked the lock: some put the key in the lock and then jiggled the door and some hit the lock and wiggled the door.

In a follow-up interview on 10/10/18 at 10:30 a.m. the Education Director said Staff H received training from Staff J, CNA (a trainer currently out of the country) and also by Staff U, CNA, who also was a trainer at that time. The Education Director stated she had a trainer meeting on 7/19/18 and changed the checklists/definitions to update. The Education Director changed staff rounds to refer to the checklist. The Education Director stated the Shift Checklists used for training the trainers and used as a reference for them to train the CNA's. The Education Director showed it listed to check the courtyard gates and the task sheet listed to check the lock itself. She retrained staff on 7/19/18 after she made changes to the format and had the trainers demonstrate locking the gate and checking the gate. The Education Director stated the trainers had access to the definitions of what to say like a tutorial for the trainers, not passed out to everyone. At 1:50 p.m., the Education Director stated she first learned of variations in how the staff checked the gate after the elopement when they expected each staff member to complete return demonstrations. With the current training they had staff do return demonstrations initially and after the incident. The Education Director

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F 689	Continued From page 32 said after the elopement when the staff showed her, some showed they pushed on the button with a hand and some locked and relocked it but as long as they knew how to lock and secure the door that's what she looked for. The Trainer Definitions prior to 7/19/18 for Change of Staff Report/Rounds documented the check should be done at the beginning of the shift and staff should refer to the checklist. The Shift Checklists/Staff Cleaning for Oncoming Shift included direction to check the courtyard gate for security and initial the check on the task sheet. For CNA/Nurse Communication Sheet ("Task Sheets"), the gates should be checked during report and rounds - check the lock itself to make sure it is locked. The Trainer Definitions updated on 7/19/18 for CNA/Nurse Communication Sheet documented Gate Check - Check the lock itself on the gate that it is locked and secure. Do not just wiggle the door. For Locking and Unlocking Courtyard Gates - Orientee should demonstrate how to unlock/open gate in an emergency and lock/secure gate. Additional staff interviews revealed the following information: On 10/10/18 at 11:00 a.m., Staff K, CMA (certified medication aide) stated she checked the gates every shift and had been trained to push on the button. If not locked, it opens and you need to lock it by putting the key in the lock. On 10/10/18 at 11:02 a.m., Staff L, CNA, stated she was trained to push on the button and to push door too as it could be unlocked. About 2	F 689		

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F 689	Continued From page 33 months ago, she received training to push the button when she checked to gates. On 10/10/18 at 11:04 a.m., Staff M, CNA, stated she started work on 7/6/18 and the Education Director trained her to put the key in and shove the lock and door afterward. On 10/10/18 at 11:06 a.m., Staff N, CNA, stated she was trained to check the gates where they put the key in: push on it, push on the gate and its locked if the button will not go in. Staff N said she never put the key in to check if locked. Staff N started working August 2017 and received training on the first or second day. Staff N stated that sometimes the Education Director did assessments of them and once a month they got new people she trained because she worked as a trainer. In an interview on 10/10/18 at 11:08 a.m., Staff O, CNA, stated she worked for the facility since December 2017 and received locked gate training when she first started. She received more training 2 months prior due to some confusion on how to know if the gate locked or unlocked. Staff O said she was trained to push on the button and if the button pushes in, it's not locked. You should push and shake the door. In an interview on 10/10/18 at 11:10 a.m., Staff P, CNA, stated she worked for the facility since June 2018. Staff P stated she was trained on gate checks a couple times by the Education Director; first on the Dogwood neighborhood then a second time on the Cottonwood neighborhood. Staff P learned each shift to take the keys out to turn to the lock and to push it and see if the gate moved.	F 689		

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F 689	Continued From page 34 A paper with a fax date of 10/1/18 as documented by the Administrator recorded: At approximately at 2:00 p.m. the Administrator spoke with Staff F, CNA, and Staff G, CNA, both CNA's worked Maple on the 6 to 2 shift on 9/1/18. Both aides stated that they checked their gate in the morning and that the gate was locked. Both aides reported that no one used the courtyard on their shift. The Administrator documented the following internal investigation: On 9/1/18 at approximately 6:15 p.m., Staff C, RN, called the Administrator and informed her that Resident #17 was out in the courtyard with a staff member and a couple of other residents. A resident in the dining area needed immediate assistance, she assisted that resident and came back out. She assisted the other two residents inside and under the impression the other resident walked himself back in. As she entered the common area a family member walked in with Resident #17. The CNA immediately checked the gate for proper function and made sure it locked. She also did head count on the neighborhood to ensure all residents were accounted for. The Administrator instructed Staff C to immediately start 15 minute checks on Resident #17 and to add him to their hot list for the next 7 days. On 9/2/18, the Administrator documented at approximately 10:00 a.m. she checked all gates to ensure they functioned properly and locked. All gates were locked. The Administrator started immediate education with nursing staff on expectations of when checks are to be done on	F 689		

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F 689	Continued From page 35 the courtyard gates. The Administrator also created a log of random checks that would be done on courtyard gates by department heads. The lack of supervision and systematic gate checks resulted in Immediate Jeopardy for facility residents. The facility abated the Immediate Jeopardy situation on 10/10/18 by educating staff on a consistent system to check the gate lock and requiring return demonstration at the time of that training.	F 689		

Arbor Springs Plan of Correction

F582- Medicaid Coverage/Liability Notice

Facility has had a change in Social Service Coordinator. Facility has obtained appropriate ABN forms. Social Worker will complete forms and ensure timely notification to families.

Compliance date: 11/9/2018

F623- Notice Requirements before transfer/discharge

Social Service Coordinator/assigned designee will submit notification to LTC ombudsman on a monthly basis.

Compliance date: 11/9/2018

F625- Notice of Bed Hold Policy before/upon transfer

Facility has created a new bed hold form. The Charge Nurse is responsible for initiating the bed hold conversation with the family at the time of resident transfer. If the family is present, family will sign the form at that time. If the family is not present, Social Worker will follow up with the family the following business day to obtain signature of responsible party.

Compliance date: 11/9/2018

F684 Quality of Care

For resident #15 and all other similarly situated residents' physician orders will be followed to provide quality of care.

Going forward, physician ordered skin treatments will be time limited or written until healed. Arbor Springs will utilize the abbreviation "UH" on orders.

Nurses will receive education on obtaining skin treatment orders by Co-DON.

All open skin areas will be assessed on a weekly basis. Once areas are healed, it will be indicated on the weekly skin assessment.

Director of Nursing or Designee will provide random audits that skin treatment orders are time limited and followed.

Compliance date: 11/9/2018

F637 Comprehensive Assessment after Significant Change

For resident #15 and all other similarly situated residents:

1. Significant Change Assessments will be completed when a resident is admitted to hospice services and when a resident is discharged from hospice services.
2. Our new MDS Coordinator began 8/13/18 and has received education and training on the MDS on August 9th 2018 and September 13th 2018.
3. Co-DONs or Designee will complete random audits on residents who are admitted to and discharged from hospice services to make sure a significant change is being completed as required.

Compliance date: 11/9/2018

F622 Transfer and Discharge Requirements

For resident #49 and all other similarly situated residents.

A transfer sheet will be completed at the time of a resident's discharged. This transfer sheet will provide discharge and medical information to the receiving institution. A copy will also be maintained for our facility records.

Compliance date: 11/9/2018

F689- Free of accidents/hazards/supervision/ devices

- Procedures written for
  - Supervision of Courtyard
  - Courtyard Gate Security
  - Conducting head count of residents
  - All Staff were educated before working their next shift on these three procedures.
- New employees will receive courtyard gate education and complete a return demonstration during assimilation. This will be completed by a Dept. Head.
- Department Heads will continue to conduct random checks of gates to ensure they are locked for four weeks. QA team will assess after four weeks to determine if continued audits are needed.
- Department Heads will randomly select 2 CNA's per week to perform a return demonstration on properly checking the gate for security for four weeks. QA team will assess after four weeks. QA team will assess after four weeks to determine if continued audits are needed.

Compliance date: 10/15/2018