STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165350	A. BUILDING _____ B. WING _____	C 10/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAIN WEST HEALTH CENTER	1501 OFFICE PARK ROAD WEST DES MOINES, IA 50265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date: 10-5-17 Complaint #70925-C was substantiated. Investigation of facility-reported incident #70972-I resulted in facility deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review and resident and staff member interviews, the facility failed to treat all residents with dignity and respect, in recognition of each resident's individuality, for 1 of 8 total residents reviewed (Resident #4). The facility reported a census of 78 residents. Findings include: The 9/22/17 Minimum Data Set (MDS) assessment recorded Resident #4 scored 15 out of 15 points possible on the Brief Interview for Mental Status (BIMS) test indicating intact memory and cognition. The resident had no signs or symptoms of delirium and had diagnoses that included diabetes, arthritis, anxiety, depression and torticollis (a condition in which the head becomes persistently turned to one side,	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/26/2017

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F 241	Continued From page 1 often associated with painful muscle spasms). Resident #4 required the assistance of 2 or more staff for repositioning in bed, transfers to and from bed and chair, bathing, dressing, eating, toileting, personal hygiene and locomotion off the nursing unit. The resident had a urinary catheter in place and always had incontinence of bowel. The resident's care plan dated 9/29/17 documented an activity of daily living self-care performance deficit problem that included the following interventions that directed staff: 1. Assist to dress and undress slowly and gently, initiated 3/31/17. 2. Assist to position call light so it can be operated with mouth or blowing into it, initiated 5/23/17. 3. Dress resident, initiated 3/31/17. 4. Encourage and assist to brush teeth twice daily and floss daily and every hour of sleep, encourage and assist removal of upper partial to clean and soak, initiated 3/21/16. 5. Honor resident choice of preferred bedtime, initiated 3/30/17. 6. Mechanical lift transfer with 2 staff, total care for all transfers, initiated 4/18/16. The nursing care card directed that 2 staff members were to be in the room when any cares were performed, Resident #4 liked to be involved in care choices that included bedtime and to move her gently. During an interview on 9/20/17 at 7:00 a.m., Resident #4 stated approximately one week earlier, she sat up in their wheel chair at 7:45 p.m., activated the call light for assistance with oral care, Staff I, certified medication aide (CMA)	F 241		

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F 241	Continued From page 2 and certified nursing assistant (CNA) responded, turned off the call light and did not acknowledge the resident's need for assistance. The resident stated she activated the call light two additional times, Staff I responded and turned the light off the 2nd time, and the 3rd time. Resident #4 felt Staff I was angry that the resident wasn't in bed or ready for bed, in the resident's room alone and handled the resident roughly as she removed her clothes. Staff I threw the garments on the floor and handled her roughly as she dressed the resident for bed. The resident stated she reported this to the Director of Nursing (DON) the following day. During an interview on 9/20/17 at 8:24 a.m., when asked if the resident had reported the situation, the DON stated she had reported it to the Assistant DON (ADON). The ADON, present at the time, stated the resident had reported it on 9/14/17, the incident occurred on 9/13/17, the resident reported Staff I was rough but she thought the resident was more concerned about what products the staff used for oral care. The ADON stated Staff I and Staff K, CNA, had put the resident to bed the evening before the report, she asked both of the staff together if they were rough with the resident and they denied they were. The ADON said she followed up with the resident and informed her that staff used the correct oral care products, staff denied they were rough with the resident and no further action was taken. During an interview on 9/21/17 at 11:23 a.m., the Social Worker denied any knowledge of the incident and said she would speak with the resident about it.	F 241		

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F 241	Continued From page 3 During additional interview on 9/25/17 at 3:45 p.m., the Social Worker stated she spoke with the resident and the resident repeated the same story. Resident #4 stated that Staff I was upset that she wasn't in bed at 8:45 p.m., was rough with her and threw her clothes on the floor. The Social Worker stated she would follow up with the Administrator. During an interview on 10/4/17 at 2:45 p.m., the Administrator, DON and Social Worker agreed that staff should treat all residents with dignity and respect.	F 241		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, facility policy review and resident and staff interviews, the facility failed to provide oral hygiene care for 4 of 6 residents that depended on staff assistance for care (Residents #1, #2, #5 and #8) and failed to provide complete incontinence care for 1 of 4 residents sampled with urinary incontinence (Resident #5). The facility reported a census of 78 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 8/25/17 recorded Resident #1 had diagnoses that included congestive heart failure, Alzheimer's disease, Parkinson's disease, anxiety	F 312		

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F 312	Continued From page 4 and depression. The resident required the assistance of one staff member to perform personal hygiene activities. The resident's care plan, revised 8/30/17, identified a focus of activity of daily living (ADL) self-care problems and an intervention directing staff to assist resident to brush her teeth and rinse mouth every evening. A Goals of the Care Plan protocol, without a reference date, directed staff: 1. Make sure necessary items are available for personal care. 2. Oral cares are done twice a day unless specified different. Remember to allow residents who are able, time in the bathroom to brush their teeth at the sink. Allow the resident to rinse their mouth as able. Observation on 9/19/17 at 10:14 a.m. revealed a pink emesis basin, unlabeled, on shelf by sink in the bathroom, contained 2 tooth brushes and 2 different kinds of tooth paste, all unlabeled, tooth brushes hard and dry. At 12:50 p.m., the tooth brushes remained dry. Observation on 9/20/17 at 7:21 a.m. revealed the resident in bed, no change in position of items in the emesis basin and her tooth brushes remained dry. Staff J, restorative aide, entered the room at 7:58 a.m., transferred Resident #1 to a wheel chair at 8:05 a.m. and took the resident out of the room at 8:11 a.m. without providing oral care. At 9:36 a.m., the resident sat in her wheel chair by the bed and observation revealed no change in position or condition of tooth brushes.	F 312		

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F 312	Continued From page 5 Observation on 9/26/17 at 12:41 p.m., revealed two cups each labeled with resident names in the resident's bathroom and both contained tooth paste and tooth brush with the tooth brush hard and dry. Observation on 9/28/17 at 7:05 a.m., the resident's tooth brush damp and Resident #1 up in wheel chair. The Director of Nursing stated she had performed the resident's oral care that morning. During an interview on 9/21/17 at 8:21 a.m., Staff F, certified nursing assistant (CNA), stated residents should be assisted with or staff should provide personal hygiene care that included oral hygiene in the morning and the facility had oral hygiene supplies if the resident did not. 2. The MDS assessment dated 9/1/17 recorded Resident #2 had diagnoses that included congestive heart failure, esophageal reflux, Alzheimer's disease, cerebrovascular accident (a stroke) and depression. The resident required the assistance of one staff member with personal hygiene activities, that she experienced routine bowel and bladder incontinence and that she had one unhealed pressure ulcer. The resident's care plan, revised 9/6/17, contained the focus of a self-care deficit problem that instructed staff to provide set-up and supervision with teeth brushing and the resident had her own teeth. Observations on 9/19/17 at 9:34 a.m. revealed 2 tooth brushes and 2 different tubes of tooth paste located in the same emesis basin in the resident's bathroom and both tooth brushes were dry. At	F 312		

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F 312	Continued From page 6 1:18 p.m., observation revealed no change of position in the oral hygiene equipment and her tooth brushes remained dry. Observation on 9/20/17 at 6:39 a.m., Resident #2 sat up in her wheel chair in the hall. Both tooth brushes in her bathroom appeared dry. At 9:29 a.m. the resident lay in bed and both tooth brushes remained dry. Observation on 9/21/17 at 6:35 a.m. revealed Resident #2 sat in wheel chair in the hallway and both tooth brushes in her bathroom were dry. Observation on 9/26/17 at 12:38 p.m., revealed the tooth brushes felt damp when touched with a paper towel. 3. The MDS assessment dated 9/8/17 documented Resident #5 had diagnoses that included congestive heart failure, cerebrovascular accident (a stroke), Parkinson's disease, anxiety and depression. The resident required the assistance of one staff member with personal hygiene activities. The resident's care plan, revised 9/12/17, documented an activity of daily living (ADL) self-care performance deficit problem and an intervention directing staff to provide the total assistance of 1 staff for personal hygiene and oral care. Observations on 9/19/17 at 9:01 a.m. revealed one dry tooth brush in the resident's shared bathroom, no label on the tooth brush. At 12:44 p.m. and 2:05 p.m., the tooth brush remained dry. Observations on 9/20/17 at 6:36 a.m., revealed	F 312		

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F 312	Continued From page 7	F 312		

resident dressed and seated in wheel chair in the hall. A tooth brush stored in the bathroom was dry. At 9:09 a.m., the resident sat in her wheel chair in the hallway after breakfast and the tooth brush remained dry.

Observations on 9/21/17 at 6:40 a.m. revealed Resident #5 and her roommate seated in wheel chairs in the hall by their room. Resident #5 had dark orange/brown colored dried substance present on her lips, a heavy accumulation at the corners of the mouth with dry lips and tongue. The resident's tooth brush was stored and dry. During an interview at that time, Staff B, licensed practical nurse (LPN), stated the resident had not received any medication, food or drink that morning, Staff B examined the resident's mouth and tooth brush in the bathroom, stated staff had not provided oral hygiene care and should have completed the care, and she would address the matter. At 9:11 a.m., observation revealed the resident's face and lips clean, her mouth moist, with oral care swabs and a wet tooth brush in the bathroom.

Observations on 9/28/17 at 6:45 a.m. revealed Resident #5 seated in wheel chair in the hall with her lips dry and cracked in appearance and her mouth dry. When asked at that time if oral hygiene care was provided, Staff H, certified nursing assistant (CNA), stated he provided the care that morning. Observations in the bathroom revealed the resident did not have a tooth brush labeled with her name, but oral swabs were present in the bathroom.

During an interview with the DON on 9/28/17 at 7:05 a.m., when asked about the resident's oral hygiene performed that morning, she consulted

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F 312	Continued From page 8 with Staff H and stated he performed the care with the swabs and had not brushed the resident's teeth. The DON also stated they had gone through all resident's oral care supplies and ensured every resident had supplies and equipment labeled with their names and available for use. Observation on 9/28/17 at 9:35 a.m. revealed Staff H, CNA, performed incontinence care with Staff E, certified medication aide (CMA/CNA) with the DON present. Staff H wore gloves, removed the resident's wet brief, continued to wear the same gloves as he wiped the resident's perineal and rectal area from behind the resident, did not change the surface of the wipe with each pass as he wiped from the front to the back, while resident positioned on her left side. Staff H changed gloves, applied a new brief and did not cleanse the resident's frontal perineal area. 4. The MDS assessment dated 8/18/17 recorded Resident #8 entered the facility on 5/12/17. The assessment documented diagnoses that included diabetes, anxiety and depression. The resident required the assistance of one staff member with personal hygiene activities. The assessment documented she had a BIMS score of 15, indicating no cognitive or memory impairment. During an interview on 9/28/17 at 7:48 a.m., Resident #8 stated the only thing she had a hard time with at the facility was her oral hygiene care. She always had to ask or remind staff for their assistance with the care or she did not receive the care. The facility's Perineal Care policy, dated 8/7/17, directed staff:	F 312		

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F 312	Continued From page 9 1. Cleanse the perineum and other body parts that could come in contact with urine and feces, to prevent infection, odor and skin breakdown. 2. Wash perineal area, including groins, hips, buttocks, and lower abdomen with cleansing wipe, wash from front to back, use clean portion of the cloth with each wipe. 3. Use clean cleansing wipe to cleanse the anal area. 4. Apply barrier ointment to incontinent residents.	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (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, record review, and resident and staff interviews, the facility failed to provide the care and treatment necessary to prevent pressure sore development in 3 of 5 residents reviewed with facility-acquired pressure sores (Resident's #1, #4 and #5), and failed to	F 314		

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F 314	Continued From page 10 provide treatment consistent with professional standards of practice to promote healing and prevent infection of the identified pressure sores. The facility reported a census of 78 residents. Findings include: 1. Resident #4 had a Minimum Data Set (MDS) assessment with a reference date of 9/22/17. The MDS identified the resident had a BIMS (Brief Interview for Mental Status) score of 9 out of 15. A score of 9 indicated the resident had cognitive impairments. The MDS had diagnoses that included diabetes, arthritis, anxiety, depression and torticollis (a condition in which the head becomes persistently turned to one side, often associated with painful muscle spasms). The MDS indicated the resident required 2 or more people for repositioning in bed and with transfers, personal hygiene and toilet use. The MDS indicated the resident had impairments of both upper and lower extremities, had an indwelling Foley catheter and experienced bowel incontinence episodes. The MDS identified the resident at risk for the development of pressure sores and had 1 unhealed Stage III pressure ulcer that measured 2.0 cm (centimeters) by 1.5 cm by 0.1 cm depth. The MDS identified the resident had a pressure reducing device on the bed and chair, turning and repositioning program, nutrition or hydration interventions, pressure ulcer care, application of ointments and nonsurgical dressings. The Care Plan identified an impaired skin integrity problem on 4/1/15. The interventions directed the staff to do the following: Pressure reduction devices to bed and wheel	F 314		

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F 314	Continued From page 11 chair, initiated on 4/1/15. Administer treatments as ordered, initiated 11/19/15. Assist to reposition in bed every 2 hours, initiated 3/23/16. Encourage and assist to remove shoes when in bed, initiated 3/29/17. Boot to left foot when in bed, initiated on 7/20/17. Float bilateral heels when in bed, initiated 10/3/17. The Care Card, available on 10/3/17, directed the staff members to float heals in bed, no shoes, pressure reduction boot to left foot while in bed and to turn approximately every 2 hours when in bed. The resident's Wound/Skin Healing Record identified a scab on the left malleolus (ankle bone) on 6/20/17. The area measured 0.6 cm by 0.9 cm. Additional wound conditions, measurements and dates are described: 6/27/17 - 1.0 cm by 1.0 cm, without depth or drainage. 7/3/17 - 1.0 cm by 1.0 cm scab, without drainage. 7/25/17 - 1.0 cm by 1.8 cm by 0.2 cm depth, no drainage with slough tissue. 8/4/17 - 1.5 cm by 1.3 cm by 0.2 cm, scant drainage with epithelial tissue. 8/9/17 - 1.0 cm by 2.0 cm by 0.2 cm, scant drainage with epithelial tissue. 8/14/17 - 2.0 cm by 1.8 cm by 0.2 cm, scant drainage with epithelial tissue. 8/22/17 - 1.5 cm by 1.5 cm by 0.2 cm, without drainage and with epithelial tissue. 8/30/17 - 2.0 cm by 1.5 cm by 0.2 cm, without drainage, slough tissue. 9/5/17 - 1.0 cm by 1.0 cm by 0.2 cm, without	F 314		

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F 314	Continued From page 12 drainage, slough tissue. 9/13/17 - 1.0 cm by 1.0 cm by 0.2 cm, with drainage, granulation tissue. 9/18/17 - 1.5 cm by 1.5 cm, without drainage, granulation tissue. 9/27/17 - 2.0 cm by 1.5 cm by 0.1 cm, scant serous drainage, slough tissue. On 10/3/17 at 6:20 a.m. observation with Staff A, licensed practical nurse (LPN), identified the resident positioned in bed, without heels floated/suspended. Staff A removed the gauze cover dressing, the Hydrofera Blue dressing adhered to the skin, Staff A used an opened bottle of normal saline with approximately 30 to 50 milliliters in it and in 1 lateral motion, applied the entire surface of the bottle opening to the skin around the dressing. Staff A then removed the Hydrofera Blue that was then wet by the process. Observation identified a wound approximately 1.0 by 2.0 cm by 0.2 cm depth wound on the left lateral malleolus. The wound was located at the normal resting position of the ankle's contact with the mattress. Observation identified the wound with white slough tissue; an approximate 0.2 cm border of slightly darker pink tissue surrounded the wound opening. The wound had no visible drainage noted. Staff A replaced the cap to the saline bottle. Physician orders directed staff to do the following: 6/23/17 - Apply Allevyn patch to scabbed area on the left malleolus. Change every 3 days for 15 days, then reassess. This order was discontinued on 6/28/17 per physician. 6/28/17 - Cleanse area on left ankle with normal saline (NS), pat dry, apply Skintegrity to wound bed daily, cover with Telfa gauze and rolled gauze	F 314		

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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 314	Continued From page 13 daily for 7 days. Reassess (end of orders 7/5/17). 7/12/17 - (7 days without wound care orders or wound treatment) Apply Mepilex Ag [silver] to wound area, secure with rolled gauze in figure 8, change daily for 14 days then reassess. 7/27/17 Cleanse wound with NS, apply Skin Prep to peri wound, allow to dry. Apply small amount Medihoney to wound base, cover with 2 inch by 2 inch gauze and secure with Tegaderm (clear adhesive dressing), change every other day. 8/24/17 Skin Prep to peri wound, allow to dry completely, calcium alginate cut to fit wound bed, moisten with scant amount of NS and cover with 2 inch by 2 inch island dressing, change daily for 14 days then reassess (end of orders 9/7/17). 9/12/17 - (5 days without wound care orders or wound treatment) Cleanse left foot ulcer daily with NS, pat dry, apply Skin Prep to peri wound, moisten calcium alginate with scant amount of NS and cover with 2 inch by 2 inch island dressing. 9/13/17 -Cleanse wound with NS, cut Hydrofera Blue to fit wound bed, cover with island dressing, change daily for 14 days (end of orders 9/27/17). 10/3/17 - (5 days without wound care orders or wound treatment) Cleanse left foot ulcer with NS, pat dry, apply Skin Prep to peri wound, moisten calcium alginate with scant amount of NS and cover with 2 inch by 2 inch island dressing daily for 7 days then reassess. Observations of the resident identified the following:	F 314		

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	165350	A. BUILDING _____ B. WING _____	C 10/04/2017

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F 314	Continued From page 14 9/20/17 at 6:58 a.m., in bed and awake, heels floated with a blue pillow device. 9/21/17 at 10:28 a.m., in bed, eyes closed and covered with blanket, legs appear elevated on a device to float heels, covered with blanket. 10/3/17 at 5:44 a.m., CNA (certified nursing assistant) left the resident's room and said the resident was asleep. Observations from the hall revealed the resident's feet on the mattress, not floated, and the blue flotation pillow on the floor by the closet 10/3/17 at 6:20 a.m., resident's feet remained directly on the mattress, the blue flotation pillow remained on the floor, the resident was awake and stated staff had not floated her heels all night, and they were supposed to. On 9/21/17 at 7:42 a.m., the Director of Nursing (DON) stated the resident's pressure sore on the heel probably resulted because staff had not floated her heels as they should have. The DON stated the resident was repositioned about every 2 hours and would have had the opportunity to float the resident's heels with each reposition. On 10/4/17 at 1:25 p.m., the DON stated they had tried the blue boots on the resident a while ago and the resident didn't care for the boots. The DON stated the staff are to float the resident's heels with the blue pillow when in bed. 2. Resident #5 had a MDS assessment with a reference date of 9/8/17. The MDS indicated the resident had diagnoses that included congestive heart failure, cerebrovascular accident (a stroke), Parkinson's disease, anxiety and depression. The MDS indicated the resident required extensive assistance of at least 1 staff member	F 314		

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F 314	Continued From page 15 for repositioning in bed and need 2 or more staff to help with transfers. The resident depended upon staff for personal hygiene, toilet use, eating and dressing. The resident always had bowel and bladder incontinence and at risk for the development of pressure ulcers. The MDS identified the resident had no pressure ulcers at the time of the assessment and the facility used only a pressure reducing device in the chair (not in bed). The Care Plan identified on 7/24/13, an impaired skin integrity problem. The interventions included and directed the staff to do the following for the problem: Assist to reposition in bed approximately every 2 hours, initiated 6/9/17. Discourage being up in wheel chair for prolonged periods of time and assist to reposition, initiated 6/9/17. Pressure reduction device to bed and wheel chair as appropriate, initiated 7/24/13. Provide treatments as ordered, initiated 7/24/13. The Care Card directed the staff to change the resident, reposition every 2 hours, and lay the resident down between meals. The Centers for Medicare and Medicaid Services (CMS) identify the following stages of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis	F 314		

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F 314	Continued From page 16 presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. A Wound/Skin Healing Record identified the resident had a Stage I pressure sore, located on the upper coccyx on 9/13/17. The Stage I pressure ulcer measured 2.5 centimeters (cm) by 1.0 cm, without drainage, epithelial tissue present in wound bed and normal colored surrounding tissue. The next assessment, completed 9/27/17 identified the area measured 2.3 cm by 1.0 cm by 0.1 cm depth, without drainage, epithelial tissue present and normal colored surrounding tissue [Stage II]. Observation on 9/28/17 at 9:35 a.m. identified the DON present as Staff O, CNA removed the resident's urine soiled brief. Observation identified an approximate 1.0 cm to 1.0 cm circular open area that appeared as a dark purple or brown colored tissue. The peri-wound had a margin of bright red tissue that extended approximately 1.0 to 1.5 cm from the eschar edge, centrally located on the coccyx area.	F 314		

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F 314	Continued From page 17 Physician orders directed the following: 9/14/17 - Apply Dermagran ointment (Aluminum hydroxide) to coccyx wound 3 times a day for 14 days, then reassess (end of orders 9/27/17). 10/3/17 - Cleanse wound with wound cleanser, pat dry, apply Dermagran ointment 2 times daily for 14 days then reassess (5 days without wound care orders or treatment). Observations of the resident revealed: 9/20/17 at 6:36 a.m., dressed and seated in wheel chair in the hallway. 9/20/17 at 7:53 a.m., remained seated in wheel chair in the hallway, transported to the assisted dining room. 9/20/17 at 8:10 a.m., remained seated in wheel chair, in assisted dining room for breakfast. 9/20/17 at 9:09 a.m., remained seated in wheel chair in hallway near room, head slumped forward. 9/20/17 at 9:27 a.m., staff pushed resident in wheel chair into his/her room for care and transfer to bed. 9/21/17 at 6:40 a.m., resident dressed and seated in wheel chair in hallway. 9/21/17 at 7:14 a.m., remained seated in wheel chair. 9/21/17 at 7:50 a.m., seated in wheel chair in the assisted dining room. 9/21/17 at 8:25 a.m., seated in wheel chair in the assisted dining room. 9/21/17 at 8:48 a.m., returned from the dining room, remained in wheel chair. 9/21/17 at 9:11 a.m., remained seated in wheel chair in room next to bed, head slumped forward. 9/21/17 at 9:32 a.m., remained seated in wheel chair in room.	F 314		

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F 314	Continued From page 18 9/21/17 at 9:44 a.m., resident in bed. 3. Resident #1 had a MDS assessment with a reference date of 8/25/17. The MDS indicated the resident had diagnosis including congestive heart failure, Alzheimer's disease, Parkinson's disease and depression. The MDS indicated the resident had severe cognitive impairments and depended upon 1 staff person for repositioning in bed, and 2 or more staff persons with transfers and toileting. The MDS identified the resident always experienced bowel and bladder incontinence. The MDS identified the resident to be at risk for pressure sore development and had 1 Stage II pressure ulcer on 8/12/17. The MDS indicated the pressure relieving device on the chair seat only. The MDS did not address nutrition or hydration, turning and repositioning or a relieving device on the bed. The Care Plan indicated the resident had the potential for impaired skin integrity problem on 7/22/13. The interventions included and directed the staff to do the following: Assist to position to avoid prolonged periods of time in a wheel chair, initiated 12/8/16. Assist to reposition in bed approximately every 2 hours, initiated 12/8/16. Pressure reduction device to bed and wheel chair as appropriate, initiated, revised on 4/18/14 A Pressure Skin Condition Report dated 8/12/17 described a fluid filled blister on the lateral aspect of the right heel that measured 3.0 centimeters (cm) by 2.8 cm without depth. The report described on 8/17/17 the blister	F 314		

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F 314	Continued From page 19 opened, measured 4.0 cm by 1.5 cm, without depth or drainage, granulation tissue present. On 8/25/17 the wound measured 2.8 cm by 2 cm with 0.05 cm depth, without drainage, granulation tissue present. On 9/1/17 the wound measured 1.0 cm by 1.0 cm by 0.1 cm depth, without drainage. On 9/8/17 the wound measured 1.0 cm by 0.8 cm by 0.1 cm, scant drainage, epithelial tissue present, pain level of 2 determined by facial signs with 0 to 10 scale used, 10 described as worst pain, resident received scheduled pain medication. On 9/17/17 the wound measured 0.5 cm by 0.5 cm by 0.1 cm depth, scant drainage, and epithelial tissue present. On 9/22/17 the wound measured 0.6 cm by 1.0 cm by 0.2 cm depth, without drainage, epithelial tissue present. On 9/27/17 the wound measured 0.5 cm by 1.0 cm without depth, no drainage, area scabbed. Observation of wound care with the DON on 9/28/17 at 10:32 a.m. revealed the resident in bed, fully clothed with shoes on. Staff C, licensed practical nurse (LPN), removed the right shoe and sock that revealed no dressing on the wound. The wound area appeared dry, pink tissue, surrounding tissue also pink, foot warm, and measured 1.2 cm diameter, with open area 0.7 cm by 0.9 cm and approximate 0.2 to 0.3 cm depth.	F 314		

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F 314	Continued From page 20 Physician orders directed: 8/12/17 - Apply Silvadene to right lateral heel blister daily until opened, then apply Bacitracin daily until healed. The order was not implemented as documented on the Treatment Administration Record (TAR). 8/12/17 - Keflex (a strong antibiotic) 500 milligrams (mg) administered 3 times daily for 7 days related to wound. 8/20/17 - Cleanse wound right ankle area with normal saline, pat dry, apply Skin Prep to peri wound and allow to dry. Apply Solosite to wound bed and cover with 2 inch by 2 inch gauze, secured with rolled gauze in figure 8, change 2 times daily for 15 days. 8/31/17 - Continue same wound care 2 times daily for 15 days (order ended 9/15/17). 9/22/17 - (7 days without wound care orders or treatment) Apply Allevyn adhesive pad to right heel wound daily for 7 days. The facility document titled Protocol To Follow for Pressure dated 10/20/10, included and directed staff to do the following: 1. Complete assessment required when a pressure sore is first identified. 2. Documentation should include interventions implemented, orders received, and family/responsible party notification. 3. Documentation should also include use of pressure relieving devices, such as pillows to elevate heels off the bed, positioning devices, and padding to bony prominences. 4. Documentation should include repositioning if resident is unable to reposition self. 5. Weekly skin assessments are to be initiated for any pressure sore, completed by the nurse assigned to the area.	F 314		

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F 314	Continued From page 21 Resident observations: On 9/19/17 at 10:14 a.m., the resident sat in a wheel chair in room, fully dressed with white tennis shoes on feet. On 9/20/17 at 7:21 a.m., fully dressed with white tennis shoes on, lying towards right side on bed with lift sling under the resident. Continuous observation from the hall from 7:21 a.m. until 8:05 a.m. revealed the resident in bed, without staff intervention. Staff D, certified nursing assistant (CNA) and certified medication aide (CMA) and Staff J, restorative aide (RA), and transferred the resident to a wheel chair, transported to the dining room for breakfast. On 9/20/17 at 9:36 a.m., the resident remained seated in the wheel chair with shoes on. On 9/21/17 at 9:52 a.m. the resident sat in the wheel chair, dressed with shoes on as staff transferred her to bed. The shoes were removed and the blue foam boot placed on right foot. On 10/3/17 at 9:20 a.m., seated in wheel chair, dressed with blue foam boots on both feet. Staff D, CMA, stated resident is supposed to have the blue boots on at all times now. Staff D provided the current Care Card for the resident's hall that did not provide direction about the resident's feet, boots or wound. During an interview on 10/4/17 at 1:25 p.m., the DON stated the blue boots can be applied as a preventive measure, no order was required, and no product information was available as the product varied depending on when it was ordered and from what company. The DON stated the facility laundered the boots for use with other residents and some of the boots were older but remained in use if intact and cushioned in the desired area. The DON stated that she was the	F 314		

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F 314	Continued From page 22 designated wound nurse until approximately 1 month ago. The facility transferred the responsibility to the MDS nurse at that time. The DON stated she resumed the responsibility on 10/1/17 and did not have specialized wound care education other than some in-services.	F 314		

F 241 – DIGNITY AND REPECT OF INDIVIDUALITY

Accept this as Fountain West Health Center's credible allegation of compliance.

Staff was re-educated on maintaining the dignity of our resident's.

This education will also be added to the orientation process upon hire and completed by the Staff Development Manager.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of compliance 10/05/2017

F 312 – ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

Accept this as Fountain West Health Center's credible allegation of compliance.

Staff was re-educated on proper peri-care techniques, including washing of the peri area to include pelvic, hip thigh and buttocks with every brief change.

Proper peri-care techniques are also a part of the nursing orientation materials and new employees are educated by the Staff Development Manager.

Staff was re-educated on oral care and completing per facility policy

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of compliance 10/05/2017

F 314– Treatment/Services to Prevent/Heal Pressure Sores

Accept this as Fountain West Health Center's credible allegation of compliance.

Staff was re-educated on following and maintaining interventions to help prevent and heal Pressure wounds.

Resident #4, #5, and similarly situated residents are assessed upon admission for condition of skin (Resident #1 is no longer a resident of the facility). Weekly skin assessments are completed on all residents with impaired skin integrity. Treatments are monitored weekly for effectiveness and treatment changes made as needed.

Resident positioning is monitored daily on rounds and staff education provided as needed. Ongoing education will be conducted as determined appropriate by the DON. Nurses were re-educated on the importance of timely dressing changes and position changes for high risk residents.

The Director of Nursing and/or designee will monitor for compliance and the results will be brought to the Quality Assurance team at least quarterly for review.

Date of compliance 10/05/2017