STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 2/28/18 Investigation of facility-reported incident # 69358-I did not result in deficiency. Complaints # 69939-C and # 72394-C were substantiated. Investigation of facility-reported incident #72391-I resulted in deficiency. See Code of Federal Regulations (42CFR) Part 483, subpart B-C.)	F 000		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (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, facility record review and interviews, facility staff failed to display respect for residents when speaking to and caring for, as a constant affirmation of their individuality and dignity as a human being for 1 of 5 residents reviewed (Resident #1). The facility identified a census of 30. Findings include: 1. The Minimum Data Set (MDS) assessment dated 10/19/17 documented Resident #1 had diagnoses that included Non-Alzheimer's	F 241		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 241	Continued From page 1	F 241		

dementia, anxiety, depression and bilateral conductive hearing loss. The same MDS documented the resident had short and long term memory loss and had severely impaired cognitive skills for daily decision making. The resident experienced continuous inattention and disorganized thinking and she displayed physical and verbal behaviors and resisted care 1-3 days of the 7 day assessment period. Resident #1 required the assistance of two with transfers and the assistance of one with dressing and personal hygiene.

The care plan problem initiated 3/26/14 identified the resident with limited hearing and no depth perception. The care plan problem initiated 2/19/16 identified a focus area of dementia and the resident's response to certain situations or needs may be communicated by a behavior rather than appropriate verbal expression. The care plan directed staff to use a calm voice and provide simple directions.

The Progress Notes entry completed by the Director of Nursing (DON) on 11/16/17 at 8:50 AM documented the bath aide reported the resident began swinging her arms, kicking and attempting to bite the bath aide on the shoulder during bathing. The combativeness continued while the bath aide assisted the resident to dress.

During interview on 11/30/17 at 2:10 PM Staff A , certified nursing assistant/certified medication aide (CNA/CMA) stated she went to the bathing area to get the resident on 11/16/17. Staff B, CNA, reported to her the resident had been very combative during bathing. Staff A stated the resident does not like to take a bath, is combative most of the time, confused and is very hard of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 241	Continued From page 2 hearing and staff have to speak loudly even if the resident's hearing aids are in place. Staff A stated that Staff B brought the resident out of the bathing area and asked Staff A to take her as she "I sure as hell don't' want her". Staff A stated Staff B got frustrated easily but she did not think Resident #1 heard the comment. Staff A thought Staff B made an inappropriate comment. Staff B stated she believed an X-ray technician from the portable X-ray company also overheard the conversation and remark made by Staff B. During interview on 11/20/17 at 3:09 PM the X-ray technician present in the hallway stated she heard Staff B say to Staff A "do you want her? I sure as hell don't!" when in the hallway outside the bathing area. She reported the inappropriate remark to the Administrator. During interview on 11/30/17 at 1:12 PM, Staff B stated she did not recall saying anything inappropriate to the resident. She stated the resident very difficult to care for and is very heard of hearing. She bathed the resident on that day and the resident hit and kicked her. Review of the personnel file for Staff B revealed a Notice of Discipline dated 11/17/17 which documented the facility suspended Staff B suspended on 11/16/17 pending investigation and received a written warning for rude or discourteous conduct towards a resident and fellow associate. The administrator discussed alternative options to handle Staff B's frustrations.	F 241		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i)	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 281	Continued From page 3 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, facility policy reviews and interviews, the facility failed to failed to administer medications as directed by the physician and failed to clarify and transcribe physician orders per accepted professional standards for 1 of 5 residents reviewed (Resident #5). The facility identified a census of 30. Findings include: 1. The Minimum Data Set (MDS) assessment dated 11/16/17 documented Resident #5 had diagnoses that included atrial fibrillation, heart failure, high blood pressure, diabetes, chronic renal insufficiency and Non-Alzheimer's dementia. The same MDS documented the resident required staff assistance with all activities of daily living and received an anticoagulant (blood thinning) medication for 3 of the 7 days of the assessment period. a. The Progress Notes entry entered by Staff C, licensed practical nurse (LPN) on 11/16/17 at 2:12 PM documented she received an order to hold the resident's warfarin (an anticoagulant medication) and to check the resident's protime/Internationalized Ratio (PT/INR, a lab test to monitor blood clotting) on 11/17/17 and if ok, to decrease the warfarin dosage to 1.5 milligrams (mg) after PT/INR drawn. The note and order did	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 281	Continued From page 4 not document what value might be considered ok. The Coagulation Studies lab report dated 11/17/17 and received by the facility at 12:37 PM documented the resident's PT/INR measured 36.9/3.5. The report documented both values as high and listed the therapeutic range INR value for warfarin as 2 to 3 (INR values greater than the therapeutic range put the resident at risk for increased bleeding due to longer clotting time). The lab report documented Staff C faxed the report to the physician on 11/17/17. A physician order entered by Staff C dated 11/17/17 at 3:15 PM directed staff to administer warfarin 1.5 mg daily starting 11/18/17 and to continue it indefinitely. The resident's clinical record did not contain documentation of physician response regarding the elevated INR prior to initiating the warfarin 1.5 mg on 11/18/17. Review of the resident's medication administration (MAR) record for November, 2017 on 11/30/17 at 4:00 PM revealed staff administered warfarin 1.5 mg daily at 8:00 PM from 11/18/17 through 11/29/17. Further review of the resident's clinical record revealed no order to recheck the resident's PT/INR. The surveyor alerted the Administrator and Director of Nursing (DON) to this at 4:25 PM. The DON stated she would contact the physician immediately and obtain an order to draw a PT/INR. During interview on 11/30/17 at 4:40 PM, Staff C stated she received the order for the PT/INR draw for 11/17/17 . She stated she did not know what the provider meant by 'ok' for PT/INR results but stated the therapeutic range for warfarin as 2 to 3. Staff C stated she wrote the order to start	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 281	Continued From page 5 warfarin 1.5 mg on 11/18/17 after she received the PT/INR result of 11/17/17 which did indicate the resident had a high INR. Staff C stated she should not have written the order until she received clarification from the physician based on the INR level. During interview on 2/2/18 at 4:47 PM the Physician Assistant responsible for Resident #5 stated staff should have clarified what he meant by 'ok' on the order of 11/17/17. Staff should not have written the order to automatically start warfarin 1.5 mg. He stated that nurses should know the therapeutic range for warfarin but it is also listed on the lab report. Staff should have contacted him prior to initiation of the warfarin 1.5 mg as he could have ordered the continuation even if the INR above therapeutic range but nurses cannot make that determination. The PA stated he acknowledged the INR of 11/17/17 on 11/20/17 and actually did order to continue the 1.5 mg dose but he did not order a recheck of the resident's PT/INR. He stated staff should have asked about that or have a system in place to catch the lack of a recheck order as it is a standard practice for nurses to inquired about PT/INR rechecks if the physician did not order one. The facility's Anticoagulation with Warfarin, Low Molecular Weight Heparin, or Lovenox policy revised November, 2014 directed the following: Orders: Point #1. Upon receipt of an order for Coumadin, Heparin, or other Anticoagulant, initiate an Anticoagulant flow sheet or lab value book. Point #2. Anticoagulation flow sheet should be kept in the lab section of the chart. The lab value	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 281	Continued From page 6 book should be maintained with dates of all lab ordered and located in the Supervisor/Charge Nurse area. Point #6. Do not administer Anticoagulant until return order from MD. If order not received by change of shift, add "awaiting INR results and/or awaiting MD orders" on the 24 hour report to alert next shift and communicate in report. Next shift needs to check the FA machine often ad call lab if no results received or call MD if no new orders received. LAB RESULTS AND MD ORDERS MUST BE RECEIVED WITHIN 12 HOURS OF THE DRAW. Review of the INR/PT Flow Sheet for Resident #5 revealed Staff C documented the INR result on 11/17/17 of 3.5 and wrote the order for decrease the dosage of warfarin to 1.5 mg without physician notification. The form contained no date for the next PT/INR draw. b. A physician phone order entered by Staff C dated 11/16/17 at 2:59 PM directed staff administer Omnicef (or cefdinir, an antibiotic) 300 mg BID (2 times a day) for 10 days. Review of the MAR for November, 2017 revealed staff failed to administer the cefdinir 300 mg until 11/17/17 at 8:00 PM. The MAR also documented staff administered only 18 of the ordered 20 doses of the antibiotic. Observation of the facility's emergency drug kit on 11/30/17 at 4:55 PM, with Staff C present revealed the kit contained 6 tablets of ceftdinir 300 mg. Staff C stated she received the order on 11/16/17 to start the ceftdinir but she did not take any tablets from the emergency kit and is not sure why she did not.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 281	Continued From page 7 During interview on 2/2/18 at 4:47 PM, the Physician's Assistant (PA) who gave the order for the ceftdinir on 11/16/17 stated he would expect staff to initiate orders on the day they receive them. He stated there had been some conflict with the pharmacy thinking he ordered Ceftin (another antibiotic) but he clarified that order with facility staff for the ceftdinir. He stated that his records indicated he contacted the facility on 11/17/17 to check to see if the ceftdinir had been initiated and he received no reply. He stated the facility should have utilized their emergency drug supply to start the ceftdinir on the day ordered and staff should have administered all 20 doses ordered.	F 281		
F 314 SS=G	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (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:	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 8 Based on observation, record review and review of policy and procedures, the facility failed to provide the appropriate care, assessment and treatment of pressure ulcers to promote healing. The facility identified 1 resident with pressure ulcers (Resident #5) and the sample consisted of 3 residents and 2 closed records. The facility reported a census of 30 residents. Findings include: 1. Resident #5 had an admission Minimum Data Set (MDS) assessment with an admission date on 11/9/17 with diagnosis that included hip fracture, diabetes mellitus, arthritis, coronary artery disease, congestive heart failure, chronic renal insufficiency (kidney disease) and non-Alzheimer's dementia. The MDS indicated the resident required extensive assistance for completion of all activities of daily living which included transfer, bed mobility, dressing, hygiene and toileting. The MDS identified the resident had an unstageable pressure ulcer present upon admission which measured 4.4 centimeter (cm) x 4.0 cm (no depth) but had slough tissue present. The MDS indicated the resident had a surgical wound and skin tears. The Care Plan initiated 11/10/17 identified the resident in need of therapy for a fracture of the right hip and had skin issues which included a hip incision, bruising, open blisters and a pressure area to the buttocks. The Care Plan directed staff to turn and reposition the resident every 2 hours, to complete treatments as ordered and to observe the residents skin at least weekly during bathing. The hospital RN (registered nurse) Wound Care	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 9 Follow Up Note dated 11/6/17 documented the following assessment of the resident's coccyx/buttocks: The ulcer is characteristic of suspected deep tissue injury with small fluid filled blister likely from fall prior to admission located bilateral buttocks/coccyx which was not measured due to size. The ulcer is considered a deep tissue injury. The ulcer bed could not be visualized as skin is intact with red/purple under the skin and a fluid filled blister noted and had NO exposed subcutaneous tissue, muscle, tendon and bone. The skin around the ulcer described as bruised, intact and dry. There is an absent amount of exudate (drainage) from the ulcer. The Note also documented no signs and symptoms of infection and ordered the following treatment: Wound/Skin/Pressure Prevention plan of care (POC) 11/6/17: 1. Daily and PRN (as needed)-apply a single layer/painting of 3M No Sting Barrier to SDTI (suspected deep tissue injury) on bilateral buttocks 2. Follow Pressure Prevention Measures-frequent turns/repositioning, moisturize intact skin, use of Aloe Vesta Protectant Ointment to buttocks/coccyx BID (2 times a day) & PRN, elevate heels/elbows, use of heel protectant boots-Medline-if needed. If head of bed elevated >30 degrees raise the knee gatch 10-20 degrees to prevent sliding, apply waffle overlay for Braden [scale] of less than 18. The Braden Scale Assessment for Predicting Pressure Sore Risk completed 11/9/17 identified a score of 13. A score of 13 indicated the resident had a moderate risk for the development of pressure ulcer development.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 10 The Comprehensive Evaluation of Skin Inspection and Risk Factors dated 11/9/17 documented the following areas: 1. Right buttock open area 4.4 cm x 4.0 cm 2. two open areas on the left buttock which measured 1.0 cm x 1.7 cm and 2.7 cm x 2.8 cm respectively 3. left buttock area of dark skin which measured 8.3 cm x 4.2 cm Section 7 of the Comprehensive Evaluation of Skin Inspection and Risk Factors completed on 11/10/17 by the facility's wound nurse documented the resident skin needed to be inspected weekly for 4 weeks. The Fax Cover Sheet sent to the physician on 11/10/17 documented a request for a daily multivitamin with minerals due to skin breakdown. The Weekly Wound Documentation Form completed by the facility's wound nurse dated 11/16/17 documented the left buttock pressure ulcer measured 5.2 cm x 3.8 cm with moderate serosanguinous drainage with macerated wound edges. The form did not address if the ulcer improved or declined or remained stable, the stage of the ulcer or an assessment of the wound bed. The resident's clinical record did not contain assessments of both areas of the left buttock that were identified on 11/9/17. A Progress Notes entry completed by the facility's wound nurse on 11/16/17 at 8:15 AM documented the dark spot on the resident's left buttock as resolved. The Weekly Wound Documentation Form completed by the facility's wound nurse dated 11/16/17 documented the ulcer on the left buttock	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 11 measured 5.2 cm x 3.8 cm with moderate serosanguinous drainage with macerated wound edges. The form did not address if the ulcer improved or declined or remained stable, the stage of the ulcer or an assessment of the wound bed. A FAX Cover Sheet sent to the resident's physician on 11/16/17 documented the resident had 2 Stage II pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough) on the coccyx and requested an order to add Pro Stat (wound healing supplement) 30 milliliters (ml) daily to support nutritional needs. The Weekly Wound Documentation Form completed by Staff D, licensed practical nurse (LPN), and co-signed by the facility's wound nurse dated 11/24/17, documented the pressure ulcer of the left buttock measured 2.1 cm x 1.2 cm with no drainage and erythema (redness) present on wound edges. The form did not address if the ulcer improved or declined or remained stable, the stage of the ulcer or assessment of the wound bed and also documented the physician not notified. The Weekly Wound Documentation Form completed by Staff D and co-signed by the facility's wound nurse dated 11/24/17 documented the right buttock pressure ulcer measured 5.1 cm x 2.9 cm with no drainage and erythema (redness) present on wound edges. The form did not address if the ulcer improved or declined or remained stable, the stage of the ulcer or an assessment of the wound bed. Review of the resident Treatment Administration	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 Record (TAR) for November, 2017 on 11/29/17 documented staff applied barrier cream to the resident's bilateral buttocks BID from 11/10/17 through 11/29/17 at time of review. The Director of Nursing (DON) identified the facility uses Medline Nutrashield with Olivamine as barrier cream for Resident #5. On 12/1/17 at 2:43 PM the Medline wound consultant was interviewed and stated Medline Nutrashield with Olivamine is appropriate for deep tissue injury when the skin is intact. It is not recommended or used on open skin or pressure ulcers or on slough or eschar tissue. The Progress Notes entry completed by the assistant director of nursing (ADON) on 11/29/17 at 2:06 PM documented a physician order received for the resident to be seen by the mobile wound service. Observation of the resident wound care on 11/30/17 at 12:20 PM with the facility's wound nurse, DON (Director of Nursing and the Mobile Wound Service physician and nurse was completed. The resident laid on an air mattress. The following areas were identified: Wound #1-pressure ulcer right coccyx: unstageable. 2.3 cm x 1.80 cm x 0.10 depth. Tissue and wound deteriorated. Wound bed with 90% slough and 10% pink/red. Scant serosanguinous drainage present with no odor. The physician ordered to apply Santyl (an enzymatic debriding ointment) nickel-thick to the wound bed and to apply Vaseline gauze cut to fit over the wound and cover with a bordered gauze dressing. This treatment to be done daily and PRN if soiled.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 Wound #2-left medical coccyx; unstageable. 4.10 cm x 3.0 cm with 0.10 depth. Tissue and wound deteriorated. Wound bed with 90% slough and 10% pink/red. Scant serosanguinous drainage present with no odor. The physician ordered to apply Santyl nickel-thick to the wound bed and to apply Vaseline gauze cut to fit over the wound and cover with a bordered gauze dressing. This treatment to be done daily and PRN if soiled. The physician ordered a Roho (pressure relief) cushion placed in the resident's wheelchair. During an interview at 1:22 PM on 11/30/17, the mobile wound service physician stated Nutrashield ointment was not appropriate for these unstageable pressure ulcers. He stated that pressure ulcer assessments should include length, width, and depth (if any) and a description of the wound bed and surrounding skin and should be staged according to accepted professional standards. On 11/30/17 at 4:25 PM, the facility's wound nurse stated she completed the 11/16/17 wound assessments and Staff D completed the 11/24/17 assessment but were not entered into the computer until today. She stated she attended a 1-2 hour in-service presented by the mobile wound service which covered what dressings are appropriate for different wounds but has had minimal training with wound assessments. The facility wound nurse stated she measures wounds and checks the surrounding skin for signs of infection but she does not assess the wound bed or stage pressure ulcers as she did not feel comfortable. She would notify the physician if a wound deteriorated over a 2 week period. The wound nurse stated she had been completing	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165203	A. BUILDING _____ B. WING _____	C 02/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT HEALTHCARE COMMUNITY	314 SOUTH ELM STREET LOGAN, IA 51546

(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 14 wound assessment on and off for a year. On 12/1/17 at 1:35 PM the DON (former ADON) stated she did all wound assessments for the facility from 10/15-5/16. She stated she would expect staff to notify the physician if a wound deteriorates from 1 week to the next. She could not recall which staff member told her the resident had slough tissue present in the wound beds and acknowledged there is no documentation of this finding. The DON stated she completes MDS assessment and just completed a correction of a prior assessment on 11/16/17 as she did not realize the resident had 3 open areas, or which 2 were unstageable, at the time she completed the admission assessment. She said it is the responsibility of all charge nurses to notify a physician of wound deterioration as they do treatments to these areas and see them more often than the facility wound nurse. The policy and procedures titled Pressure Ulcers/Skin Breakdown Policy, revised February, 2014 directed the staff to do the following: Assessment & Recognition: 1. Nursing staff and attending physician will assess and document an individual's significant risk factors for developing pressure sores: for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall assess and document/repot the following: b. full assessment of the pressure sore including location, stage, length, width and depth, presence of exudate and necrotic tissue	F 314		

F241 Dignity and Respect of Individuality

Immediate Corrective Action:
Staff B received a written warning 11/17/18 for rude and discourteous conduct with Res 1.

Action as it applies to others:
Education completed for all staff 1/16/18 regarding the dignity policy including treating residents with respect and using appropriate communication for residents with behaviors and/or that are combative with cares.

Date of Completion: 2/23/2018

Recurrence will be prevented by:

Weekly audits will be conducted to ensure appropriate staff interaction with residents who have behaviors and/or are combative with cares x 30 days.

The results and any identified concerns will be brought to QAPI to identify the need to increase or decrease audits as necessary.

The correction will be monitored by:

DON/Designee

F281 Services Provided to Meet Professional Standards

Immediate Corrective Action:
Education completed with staff C 12/1/18 regarding obtaining clarification for Coumadin orders if the physician does not state what PT/INR values are ok and does not order a recheck date, initiating orders on the date received from the physician and may take from E-kit if the medication is not available from the pharmacy.

Action as it applies to others:
Audit completed for all residents with coumadin orders to ensure that the physician has addressed the most recent PT/INR value and all had orders to recheck the PT/INR on 12/1/18

Education completed for all licensed nurses 1/16/18 regarding the physician order and anticoagulation policy.

Date of Completion: 2/23/2018

Recurrence will be prevented by:

Weekly audits to ensure that all physician orders have been initiated on the date received x 30 days.

Weekly audits to ensure that the physician has addressed the PT/INR value, gave order for coumadin dose for value, and has ordered a PT/INR recheck date x 30 days.

The results and any identified concerns will be brought to QAPI to identify the need to increase or decrease audits as necessary.

The correction will be monitored by:

DON/Designee

F314 Treatment/Svcs to Prevent Heal Pressure Sores.
Immediate Corrective Action:

Res # 5 skin assessed by wound consulting physician on 11/30/17 and new treatments obtained for resident's wounds.

Education completed with facility wound nurse 12/1/17 regarding skin program policy including thorough documentation of wound assessment, if the wound had improved or declined, and proper physician notification for treatment.

Action as it applies to others:
Education completed for all licensed nurses 1/16/18 regarding skin program policy including thorough documentation of wound assessment, if the wound had improved or declined, and proper physician notification for treatment.

Date of Completion: 2/23/2018

Recurrence will be prevented by:
Weekly audits to ensure compliance with skin program policy x 30 days.

The results and any identified concerns will be brought to QAPI to identify the need to increase or decrease audits as necessary.

The correction will be monitored by:

DON/Designee