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 08/03/2018

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 Amended on 12/4/2018 following an IDR. Correction Date_____ Complaints #76665-C, #76773-C and #76896-C were substantiated. Complaint # 76840-C was not substantiated. Investigation of facility-reported incident # 76897-I did not result in deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff and resident interview and facility policy	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/27/2018

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

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F 600	Continued From page 1	F 600		

review, the facility failed to provide goods and services to a resident that were necessary to avoid mental anguish or emotional distress for 1 of 10 current residents reviewed (Resident #1). The facility identified a census of 78 residents.

Findings include:

A Minimum Data Set (MDS) assessment dated 6/26/18 indicated Resident #1 had diagnoses the included a urinary tract infection (UTI), diabetes mellitus, chronic kidney disease, stage 4 (CKD) and insomnia. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated moderate cognitive and memory impairment. The resident required the assistance of one staff with bed mobility, transfers and toilet use, did not walk during the assessment period and had occasional incontinence of her bowels and bladder.

A Care Plan had focus areas the included an activities of daily living (ADL's) self care deficit related to chronic obstructive pulmonary disease (COPD) and diagnosis as evidenced by a need for extensive ADL assistance revised on 5/14/18 and she had occasional bladder incontinence related to (r/t) a history of UTI's, physical limitations and CKD. The interventions/tasks included the following:

a. Assistance of one staff member for transfers.
b. The resident required extensive assistance of 1 staff for toileting.
c. Toilet schedule as prompted.
d. The resident used large disposable pull ups. Change as needed (PRN)

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F 600	Continued From page 2	F 600		

A Skilled Level of Care Progress Note form dated 7/4/18 at 5:30 a.m.. indicated the resident as alert and oriented x 3 (person, place and time).

During an interview 7/5/18 at 2:46 p.m., the resident stated the night in question she put on the call light and a tall black man answered the light, said he had another resident on a bedpan and he would return but he never came back. The resident then put her call light on again and he returned again, mouthed off and left the room and never returned. The resident indicated the staff member had been rude and she felt scared so she laid in urine all night which left her cold and stinking. In the morning a little old man (Staff M, Registered Nurse (RN)) came in and helped her get cleaned up.

During an interview 7/24/18 at 1:34 p.m., the resident stated the night in question, a male staff member came into the room, turned off the call light and left the room. The resident then put the call light right back on and he returned and said he had someone on the stool with a tone that made the resident scared. Resident #1 stated no one else had been working so she never called for assistance again because he scared her, so the resident laid in urine all night which felt dirty.

During an interview 7/24/18 at 3:13 p.m., Staff L Certified Nursing Assistant (CNA) indicated he did not do anything wrong. Staff L stated he answered the resident's call light and assisted her onto the bedpan 4 different times. He indicated at 5 a.m. the resident pulled the call light so the charge nurse answered the light while he performed rounds with the other residents.

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F 600	Continued From page 3	F 600		

A Documentation Survey Report form dated July 2018, failed to provide documentation on 7/4/18 on the 10 p.m. to 6 a.m. shift the resident had been assisted to use the toilet/bedpan and any elimination status information.

Staff M, RN provided the following written statements as dated:

a. 7/4/18 at 6:53 a.m. - He checked the resident's Jackson Pratt (JP) tube, oxygen saturation and oxygen tank around the start of the shift. Later he observed the resident's call light as on and pointed it out to the CNA. Staff M had been in the nursing office when he heard a yell. He went into the hallway and asked the CNA what happened. The CNA stated that the resident yelled at him to keep the room door open which he closed. When the staff member went into the resident's room and emptied the JP tube and checked the resident's blood sugar in the morning, Resident #1 stated that when she called the CNA he refused to help her and the resident thought he said something smart. The resident stated she had been too scared to put on the call light so she laid in urine all night. The resident's brief had been soaked as well as the bed pad and sheet. The staff member cleaned up the resident and changed the bedding. The resident denied the staff member hurt her physically but said they shouldn't let a man in here. Staff M point out that he had been a man and the resident replied 'yes, but you won't hurt me'.

b. 7/4/18 at 7:22 a.m. - Staff L had been called into the nursing office on skilled to share his side of the story regarding the allegations

A Weekly Timesheet form indicated Staff L

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F 600	Continued From page 4 worked at the facility 7/4/18 from 10 p.m. until 6:30 a.m. The facility's Abuse Prevention, Identification, Investigation and Reporting form revised 4/1/17 included the following: a. All residents had the right to have been free from verbal, sexual and mental abuse, corporal punishment and involuntary seclusion. b. These procedures should included the screening and training of employees. c. The facility would conduct an Iowa criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged who provided services to residents, prior to hire.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to properly screen all contracted agency staff employees to ensure eligibility to work to prevent abuse. A	F 607		

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F 607	Continued From page 5	F 607		

concern was identified when (Resident #1) expressed concern regarding an agency staff during the night shift. There were 4 agency staff (Staff L, N, O, P) who did not have complete background checks. The facility identified a census of 78 residents.

Findings include:

1. A Minimum Data Set (MDS) assessment form dated 6/26/18 indicated Resident #1 had diagnoses the included a urinary tract infection (UTI), diabetes mellitus, chronic kidney disease, stage 4 (CKD) and insomnia. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) (cognitive test) score of 12 out of 15 (15 is highest cognitive function), required extensive assistance of staff with bed mobility, transfers and toilet use, as non-ambulatory and occasionally incontinent of bowels and bladder.

A Care Plan had focus areas the included self-care deficit related to chronic obstructive pulmonary disease (COPD) and diagnosis as evidenced by a need for extensive activities of daily living (ADL) A revised care plan dated, 5/14/18 indicated the resident had occasional bladder incontinence related to a history of UTI's, physical limitations and CKD. The interventions/tasks included the following:

-Assistance of one staff member for transfers.
-The resident required extensive assistance of 1 staff for toileting.
-Toilet schedule as prompted.
-The resident used large disposable pull ups. Change as needed (PRN)

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F 607	Continued From page 6	F 607		

A Skilled Level of Care Progress Note form dated 7/4/18 at 5:30 a.m. indicated the resident as alert and oriented x 3 (person, place and time).

During an interview on 7/5/18 at 2:46 p.m., with Resident #1, the resident stated the night in question she put on the call light and a tall black man answered the light and said he had another resident on a bedpan and would return but never came back. The resident then put her call light on again and he returned. The man mouthed off and left the room and never returned. The resident indicated the staff member had been rude and she felt scared so she laid in urine all night which left her cold and stinking. In the morning a little old man (Staff M, Registered Nurse (RN) came in and helped her get cleaned up.

During another interview on 7/24/18 at 1:34 p.m., Resident #1 remained consistent in her recollection of events. She stated the night of the incident a male staff member came into the room, turned off the call light and left the room. The resident then put the call light right back on and he returned. He told her he had someone on the stool with a tone that made the resident scared. The resident stated no one else was working so she never called for assistance again because he scared her so she laid in urine all night which felt dirty.

During an interview 7/24/18 at 3:13 p.m., Staff L Certified Nursing Assistant (CNA) indicated he did not do anything wrong. The staff member stated he answered the resident's call light and assisted her onto the bedpan 4 different times. He indicated at 5 a.m. the resident pulled the call light so the charge nurse answered the light while

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F 607	Continued From page 7	F 607		

he performed rounds with the other residents.

A Documentation Survey Report form dated July 2018, failed to provide documentation on 7/4/18 on the 10 p.m. to 6 a.m. shift that Resident #1 had been toileted or any elimination status information.

Staff M, RN provided the following written statements as dated:

-7/4/18 at 6:53 a.m. - I checked the resident's Jackson Pratt (JP) tube, oxygen saturation and oxygen tank around the start of the shift. Later he observed the resident's call light as on and pointed it out to the CNA. Staff M had been in the nursing office when he heard a yell. He went into the hallway and asked the CNA what happened. The CNA stated the resident yelled at him to keep the room door open which he closed. When the staff member went into the resident's room and emptied the JP tube and check the blood sugar in the morning the resident stated the CNA refused to help her and the resident thought he said something smart. The resident stated she had been too scared to put on the call light so she laid in urine all night. The resident's brief was soaked as well as the bed pad and sheet. The staff member cleaned up the resident and changed the bedding. The resident denied the staff member hurt her physically but said they shouldn't let a man in here. Staff M point out that he was a man and the resident replied "yes, but you won't hurt me."

-b. 7/4/18 at 7:22 a.m. - Staff L had been called into the nursing office on skilled to share his side of the story regarding the allegations

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F 607	Continued From page 8	F 607		

A Weekly Timesheet form indicated Staff L worked at the facility 7/4/18 from 10 p.m. until 6:30 a.m.

Review of a Single Contact License & Background Check form dated 5/16/18 at 8:58 a.m. indicated Staff L, Certified Nursing Assistant (CNA) required further research related to his criminal history background check. A Record Check Evaluation form had not been returned to the agency from the Department of Human Services (DHS) which would have given the agency/facilities approval for the staff member to be employed.

A Iowa Criminal History form dated 5/17/18 indicated the staff member had been arrested on 4 separate occasions with the last arrest categorized as domestic abuse assault impeding flow of air/blood and disorderly conduct - loud or raucous noise on 10/25/16 with a penalty of suspended jail time and probation extended until 4/8/18.

During an interview with the DHS on 8/2/18 at 8:17 a.m. and 8/3/18 at 9:58 a.m. revealed the last record check evaluation on 9/1/16.

Weekly Timesheet forms indicated Staff L worked at the facility on the following dates and times:

a. 5/19/18 - 6 a.m. until 10 p.m.
b. 5/20 - 11 a.m. - 10 p.m.
c. 5/26, 5/31, 6/2, 6/3, 6/7 and 6/25 - 2 p.m. - 10 p.m.
d. 5/27 - 6 a.m. - 10 p.m.
e. 5/28 - 6:30 a.m. -10 p.m.
f. 5/29, 6/5 - 6 a.m. - 10 p.m.
g. 6/9 - 6 a.m. - 8 a.m.

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F 607	Continued From page 9 h. 6/10 and 7/3 - 6 a.m. - 2 p.m. i. 6/18 and 6/19 - 2 p.m. - 6:30 a.m. j. 6/23 - 3 p.m. - 10 p.m. k. 6/27 - 10 p.m. - 6 a.m. l. 7/2 - 6:30 a.m. - 2 p.m. m. 7/4 - 10 p.m. - 6:30 a.m. 2. Review of a Single Contact License & Background Check form dated 5/7/18 at 12:16 p.m. indicated Staff N, CNA required further research related to his criminal history background check. A Record Check Evaluation form had not been returned to the agency from DHS. An Iowa Criminal History form dated 5/9/18 indicated the staff member was arrested for interfering with official acts and operating while under the influence 1st offense. Weekly Timesheet forms indicated the CNA worked at the facility on the following dates and times: a. 7/9/18, 7/10, 7/17, 7/23, 7/24, 7/25 and 7/27 - 6 a.m. - 2:15 p.m. b. 7/11 and 7/26 - 6 a.m. - 2:10 p.m. c. 7/12, 7/16, 7/18 and 7/20 - 6 a.m. - 2:20 p.m. d. 7/13 - 6 a.m. - 2:05 p.m. e. 7/19 - 6 a.m. - 2:50 p.m. 3. Review of a Single Contact License & Background Check form dated 11/1/17 at 9:12 p.m. indicated Staff O, CNA required a further research related to his criminal history background check. A Record Check Evaluation form had not been returned to the agency from DHS.	F 607		

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F 607	Continued From page 10	F 607		

An Iowa Criminal History form dated 11/2/17 indicated the CNA as arrested for operating while under the influence 1st offense.

Weekly Timesheet forms indicated the CNA worked at the facility on the following dates and times:

a. 6/10/18 - 1 p.m. - 6:30 a.m.
b. 6/11 - 2 p.m. - 10:15 p.m.
c. (date unknown) - 6 a.m. - 2:25 p.m.

5. Review of a Single Contact License & Background Check form dated 6/15/18 at 3:32 p.m. indicated Staff P, CNA required a further research related to her criminal history background check. A Record Check Evaluation form had not been returned to the agency from DHS.

An Iowa Criminal History form dated 6/19/18 indicated the CNA as arrested as follows:

a. Theft in the 5th degree.
b. Interference with official acts.
c. Theft in the 4th degree.
d. Possession of marijuana.
e. Theft in the 3rd degree.
f. Fraudulent practice in the 2nd degree.
g. Possession with an intent to deliver
h. Possession with an intent to deliver crack cocaine.
i. OWI first offense and possession of a controlled substance.

During an interview 8/1/18 at 3:35 p.m., the Director of Nursing and Administrator confirmed the owner of the staffing agency who employed

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F 607	Continued From page 11 the above 3 staff members confirmed he failed to complete the last step of the criminal background checks by sending the Record Check Evaluation form to DHS for approval to work with the elderly/dependent adults. An Abuse Prevention, Identification, Investigation and Reporting form revised 4/1/17 included the following: b. The facility would conduct an Iowa criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged who provided services to residents, prior to hire in the manner prescribed under 481 Iowa Code. On 8/1/2018, the facility abated the immediate jeopardy (IJ) after developing a policy to include screening for agency employees. The facility removed agency staff from the schedule whose criminal checks were not completed. The facility also had the agencies send all checks over to the facility prior to allowing an agency employee work within the facility. These findings lowered the IJ from a "L" severity level to an "F" with ongoing monitoring to ensure agency staff are thoroughly screened.	F 607		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		

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F 656	Continued From page 12	F 656		

medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review and staff interviews, the facility failed to follow interventions for the comprehensive plan of care and/or develop an accurate care plan that

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reflected the services provided for 2 of 10 current residents reviewed (Residents #3 and #5). The facility identified a census of 78 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment dated 5/11/18, Resident #3 had diagnoses that included Alzheimer's disease, Non-Alzheimer's dementia, Parkinson's disease, disorientation, malaise, abnormal involuntary movements, difficulty walking and weakness. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 (which indicated severe cognitive impairment), she did not walk during the assessment period and as dependent on staff with activities of daily living (ADL's). The assessment also documented Resident #3 had limited range of motion (ROM) on both sides of her upper and lower extremities.

Restorative Documentation ROM forms dated April, May and June 2018 directed the staff to perform active assist ROM to both of her upper and lower extremities 10-15 repetitions times 2 sets on each plane as the resident allowed and/or tolerated 3-5 times a week.

The resident's care plan revised on 3/18/18 failed to address the resident's ROM exercises.

2. The MDS assessment dated 6/8/18 indicated Resident #5 had diagnoses that included high blood pressure, cerebrovascular accident (CVA), Non-Alzheimer's dementia, closed fracture of the left lower radius (wrist), disorientation and tinnitus (ringing in the ears). The assessment indicated the resident had a BIMS score of 10 (moderate

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cognitive impairment), she required the assistance of one staff with transfers, ambulation, locomotion, dressing and personal hygiene. The resident had ROM impairment on one side of her upper extremities.

An observation 7/23/18 at 10:10 a.m. revealed 2 signs posted on the wall behind the resident's easy chair visible to all staff and visitors which read as follows:

a. Please use an Equagel cushion in the recliner and wheel chair, thanks therapy (not dated)

b. Please encourage the resident to remove the wrist brace when seated in the chair and or move the wrist (not dated).

An Occupational Therapy (OT) Outpatient Therapy Daily Treatment Note dated 5/1/18 included the following documentation:

a. The therapist noted the Equagel cushion only in the recliner and not in the resident's wheel chair on that date. The therapist placed a written reminder for staff above the patient's recliner.

An Outpatient Therapy Daily Treatment Note form dated 7/3/18 indicated the therapist educated the family the patient did not have to wear her wrist splint all the time and the staff and OT encouraged the resident to remove the splint when seated in the chair in her room.

The resident's Care Plan included the following focus areas, interventions and tasks as dated:

a. She had moisture associated skin damage

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to the left of the coccyx dated 4/25/18. The care plan failed to address the use of a cushioning device in the wheel chair and/or easy chair (the note posted on the resident's wall behind her recliner directed staff to place an Equagel gel cushioning device in the recliner and wheel chair per therapy)

b. Ishemic stroke as evidenced by a need for assistance with ADL's.

1. The resident walked with a platform wheeled walker and 1 assist with a gait belt to and from meals. Bring a wheel chair behind to allow the resident to sit as needed (PRN).

2. The care plan failed to address the proper usage of the resident's wrist brace.

An observation on 7/23/18 at 10:10 a.m. revealed the resident sitting in her recliner without a cushioning device under her and with her wrist brace on. At approximately 10:15 a.m. the Director of Nursing (DON) entered the room and confirmed the cushioning device as not positioned under the resident as she sat in the recliner. The DON asked the resident about the wrist brace. Resident #5 confirmed she had been directed to remove the brace. However staff failed to encourage her to remove the brace that morning and she did not remove it herself.

An observation on 7/10/18 at 2:50 p.m. revealed Staff C, Certified Nursing Assistant (CNA) assisted the resident to her room and positioned her in a recliner without a cushioning device present. Staff C did not encourage Resident #5 to remove her wrist brace. During an interview at that time, Staff C stated she did not pay attention and then placed the cushioning device in the resident's recliner.

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F 656	Continued From page 16 Observations on 7/23/18 at 10 a.m. and 12:25 p.m. revealed the resident walked with the assistance of 1 staff, using a wheeled walker without a platform and a gait belt, but without a wheelchair propelled behind the resident.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 observation, clinical record review, resident, staff, family and physician interview and facility policy review, the facility failed to follow physician's orders for 4 of 10 current residents reviewed (Residents #3, #5, #6 and #10) The facility identified a census of 78 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 5/11/18, Resident #3 had diagnoses that included Alzheimer's disease, Non-Alzheimer's dementia, Parkinson's disease, disorientation, malaise, abnormal involuntary movements, difficulty walking and weakness. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 (which indicated severe cognitive impairment), she did not walk during the assessment period and as dependent on staff with activities of daily living (ADL's). The assessment documented Resident #3 received a	F 658		

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scheduled pain regimen and she experienced occasional moderate pain.

A Medication Review Report signed by a Nurse Practitioner 6/22/18 ordered staff to administer Hydrocodone-Acetaminophen tablet by mouth 4 times a day, give at meals or after meals per family request.

During an interview 7/26/18 at 4:30 p.m. the Director of Nursing (DON) confirmed the facility's meal times as 7:30 a.m., 12:00 p.m. and 5:30 p.m.

A Controlled Substance Drug Record form documented Resident #3 received the medication on the following dates and times:

a. 7/14/18 - 6:30 a.m., 11 a.m. and 4 p.m.
b. 7/15 - 4 p.m.
c. 7/16 - 11 a.m. and 4 p.m.
d. 7/17 - 4 p.m.
e. 7/18 - 6:30 a.m., 10:30 a.m. and 3:30 p.m.
f. 7/19 - 11:30 a.m. and 4 p.m.
g. 7/21 - 4 p.m.
h. 7/22 - 4 p.m.
i. 7/23 - 6:30 a.m., 10:30 a.m. and 3 p.m.
j. 7/24 - 4 p.m.
k. 7/25 - 6:40 a.m., 11 a.m. and 4 p.m.
l. 7/26 - 4 p.m.

2. The MDS assessment dated 6/8/18 indicated Resident #5 had diagnoses that included high blood pressure, cerebrovascular accident (CVA), Non-Alzheimer's dementia, closed fracture of the left lower radius (wrist), disorientation and tinnitus (ringing in the ears). The assessment indicated the resident had a BIMS score of 10 (moderate cognitive impairment), she required the

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assistance of one staff with transfers, ambulation, locomotion, dressing and personal hygiene. The resident had range of motion (ROM) impairment on one side of her upper extremities.

a. A Physician's Order Sheet and Progress Notes form dated 5/22/18 at 9:45 a.m. directed staff to ambulate (walk) the resident at least 3 times a day (TID) in addition to meals in order to build strength and endurance and that ambulation helped to decrease another CVA.

Restorative Forms dated May and June 2018 directed staff to use a platform wheeled walker and one person assistance with a gait belt to and from meals, pulling a wheel chair behind the resident so she could sit as needed. The facility failed to ambulate the resident on the following dates:

a. May 14 th, 16 th, 18th through the 21st and the 25th through the 27th.
b. June 2nd, 3rd, 8th through the 10th, the 13th, 16th, 17th and the 30th.

Restorative Forms dated July 2018 directed staff to use a platform walker and one person assistance with a gait belt and to walk the hallways mid-morning and afternoon time (BID). The facility staff failed to ambulate the resident on July 1st, 2nd, 6th through the 8th, the 14th though the 17th, 21st , 22nd, and the 24th through the 31st.

b. A Progress Notes form dated 5/4/18 at 7:45 a.m. documented a physician's order to check the resident's blood pressure (BP) and pulse (P) every (Q) 1 hour times (x) 4 and Q 4 hours x 4.

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A Fountain West Health Center 24 Hour Sheets form dated 5/4/18 indicated the facility received a physician's order to check the resident's BP and P Q 1 hour x 4 and Q 4 hours x 4 related to a medication error. The form documented the facility failed to check the resident's BP and P Q 4 hours x 4.

3. The MDS assessment dated 5/18/18 documented Resident #6 had diagnoses that included high blood pressure, artherosclerotic cardiovascular heart disease, peripheral vascular disease (PVD), Alzheimer's disease and Non-Alzheimer's dementia. The assessment indicated the resident had the ability to make herself understood and understood others, had a short term memory deficit made independent and reasonable decisions (staff were able to conduct a BIMS test). Resident #6 required the assistance of one staff with most ADL's.

A Medication Administer Record (MAR) dated 7/1 to 7/31/18 documented a physician's order for Metoprolol Tartrate tablet 25 milligram (MG) 0.5 tablet by mouth in the morning for high blood pressure to hold if BP measured below 100 or her pulse below 55 with a start date of 9/1/17 and 1.5 MG tablet in the afternoon with a start date of 9/1/17. The form indicated on 7/5/18 the resident had a BP of 103/64 and a pulse of 88 for the morning dose and a BP of 103/64 and a pulse of 99 for the afternoon dose.

An observation on 7/5/18 at 4:30 p.m. revealed Staff K, Certified Medication Aide as he administered the resident's Metoprolol 25 MG 1.5 tablet without checking the resident's BP or pulse. During an interview at the same time the staff member pointed to the day shift BP and pulse

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and stated that is for today.

During an interview 7/6/18 at 4:42 p.m. the resident's physician confirmed the facility had a protocol in place to check the resident's BP and pulse prior to administering Metoprolol and to hold if the BP was below 100 and pulse below 55.

During an interview 7/9/18 at approximately 3:30 p.m., the Director of Nursing (DON) confirmed the facility policy had been to check the resident's BP and pulse prior to the administration of Metoprolol.

The facility protocol signed by the Physician 2/4/17 read as follows:

In conjunction with the Director of Nursing at Fountain West Health Center, I have set the following parameters regarding physician notification for resident who received Metoprolol: Please hold medication and notify the Physician if the pulse registered below 55 or the BP below 100.

4. The MDS assessment dated 6/8/18 recorded Resident #10 had diagnoses including anemia and CVA. The assessment indicated the resident had a BIMS score of 7 (severely impaired cognition) and she the assistance of 2 with transfers and toilet use and the assistance of 1 with bed mobility, dressing and toilet use. The assessment documented the resident had no skin issues at the time.

A Verbal Physician's Order form dated 7/13/18 at 6:15 p.m. directed staff to cleanse a partial thickness wound (PTW) on the right hand with normal saline topped with triple antibiotic

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ointment, then cover the wound with Telfa and wrap it with gauze once daily in the morning.

A Treatment Administration Record (TAR) form dated 7/1/19 thru 7/31/18 documented Staff E, LPN performed the treatment on 7/23/18 and Staff H, CNA/CMA performed the treatment on 7/24/18.

During an interview 7/25/18 at 11:23 a.m., Staff E stated she performed the resident's treatment that morning and removed the same dressing she placed on 7/23/18 because she dated and initialed the dressing 7/23/18 which had been the same dressing she removed that morning. An observation at the same time revealed the dressing dated 7/23/18 with the initials of Staff E.

During an interview 7/27/18 at 9:55 a.m., Staff H, CNA/CMA stated she thought she signed off the treatment on the TAR prior to having provided the treatment, gathered the supplies, assisted another resident who had been about to fall, returned to the treatment supplies, forgot who they were for and threw them away. The staff member confirmed she failed to have performed the treatment per physician's order.

During an interview 7/25/18 at 11:03 a.m., Staff E, Licensed Practical Nurse (LPN) confirmed the facility directive had been to check the resident's blood pressure (B/P) and pulse (P) prior to administration of Metoprolol and it had not been acceptable to have used another nurse's assessments. If either had been to low she held the medication and called the physician and family.

During an interview 7/25/18 at 10:22 a.m., Staff F,

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F 658	Continued From page 22 LPN confirmed the facility directive had been to check resident's B/P and P prior to administration of Metoprolol and it had not been acceptable to have used another nurse's assessments. During an interview 7/25/18 at 2:12 p.m., Staff G, Certified Medication Aide (CMA) confirmed the facility directive had been to check the resident's B/P and P prior to administration of Metoprolol and it had not been acceptable to have used another nurse's assessment. Review of a Medication Administration Policy and Procedure form (not dated) directed: a. Compare the order on the bubble pack to the Medex to make sure it had been correct by checking the medication label to the MAR including the right time. b. Verification of the medication information, as to the name of the rug, strength, dose and hours of administration.	F 658		
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. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interviews, the facility failed to provide the	F 684		

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necessary assessment for a resident reviewed with a condition change (#4) of ten current residents reviewed. The facility identified a census of 78 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 6/15/18 recorded Resident #4 had diagnoses that included a seizure disorder, malignant neoplasm of the right breast, secondary malignant neoplasm of the brain, acute pancreatitis, abdominal pain, disorientation and fatigue. The assessment indicated the resident had a BIMS score of 3 out of 15, (severe cognitive impairment), had fluctuating inattention and disorganized thinking and required the assistance of one staff with most ADL's.

The resident's Care Plan updated on 3/19/18 contained focus areas that included delirium and cognitive loss related to (r/t) secondary malignant neoplasm of the brain, delusional disorders and disorientation as evidenced by (AEB) inattention and disorganized thinking during assessment. The resident had a terminal prognosis r/t metastatic breast cancer and secondary malignant neoplasms of the brain AEB by Hospice services. The interventions included the following as dated:

a. Monitor/record/report new onset of signs and symptoms of delirium; changes in behavior, altered metal status, wide variation in cognitive function throughout the day, communication decline, disorientation, lethargy, restlessness and agitation, altered sleep cycle, dehydration, infection, delusions and hallucinations (initiated on 3/19/18).

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b. Record vital signs monthly and as needed or ordered.

c. Work cooperatively with the Hospice team which ensured the resident's spiritual, emotional, intellectual, physical and social needs were met (initiated on 3/19/18).

A Medication Administration Record (MAR) form dated 7/1/18 through 7/31/18 recorded Resident #4 received Morphine Sulfate ER (extended release) 15 milligram (mg) tablet and a 30 mg tablet by mouth (po) every 8 hours related to a malignant neoplasm of an unspecified site of the right female breast.

During an interview 7/6/18 at 12:50 p.m. the Hospice Nurse stated on 7/3/18 at 6:30 p.m., Staff I, Licensed Practical Nurse (LPN) called and left a message with their call center and requested a Hospice Nurse visit and an assessment. The Hospice Nurse returned call at 6:35 p.m. and 6:43 p.m.; however no one at the facility answered the telephone. The Hospice Nurse took care of another medical situation and arrived at the facility at 8:37 p.m.. Before the Hospice Nurse entered the resident's room she visited with Staff I who informed her the resident had a condition change, had been in bed all day, had trouble swallowing so staff crushed her meds and the resident's color had been different.

A Visit Note Report form dated 7/3/18 indicated the Hospice Nurse arrived at the facility at 8:37 p.m.. The narrative included the following information:

An as needed (PRN) visit made per facility

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request. Staff I reported the patient had been in bed all day and had more difficulty swallowing and Staff I felt the resident was transitioning. Staff I stated the resident now received crushed medications and requested to stop all non-palliative medications and to utilize liquid morphine. When the Hospice nurse entered the resident's room, the resident was awake, dressed, sitting in a hair and eating pizza without difficulty and with family present. The family reported when they arrived the resident had been lethargic, diaphoretic and in bed sleeping. The patient became more alert and conversant with time.

Review of the facility's Progress Notes on 7/3/18 failed to include an assessment of the resident's physical condition and/or change. Staff made an entry at 4:29 p.m. which documented the resident had been 0 (zero) alert enough to have taken medications so the CMA held her meds.

During an interview 7/6/18 at 11:56 a.m., Staff I stated he called the resident's family and stated the resident had a condition change on 7/3/18 of unresponsiveness, diaphoreses and in bed all day with her eyes closed which he felt uncharacteristic of the resident. Staff I felt he should err on the side of caution so that had been why he called the family.

During an interview 7/9/18 at 2:50 p.m., the Director of Nursing (DON) stated staff should have assessed the resident's condition change on 7/3/18 and not having taken medications would have been a condition change for Resident #4. Staff should not have left the assessment for the Hospice nurse's arrival.

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	165350	A. BUILDING _____ B. WING _____	C 08/03/2018

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F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, resident, family and staff member interviews and review and clinical records and resident council minutes, the facility staff failed answer resident call lights in a timely manner (no longer than 15 minutes) for 5 of 10 current residents reviewed (Residents #1, #5, #7, #8 and #9) and for residents present during the	F 725		

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Group resident interview. The facility identified a census of 78 residents.

Findings include:

1. An observation 7/23/18 beginning at 12:37 p.m. revealed the call light as on in the room of Resident #7 and #8. During continued observation, the following is a timeline of events occurred:

a. 12:45 p.m. - A female agency certified nursing assistant (CNA) and Staff A, CNA propelled 2 separate residents to their rooms down the same hallway as the residents and with their call light in view.

b. 12:46 p.m. - Another unknown female CNA walked past the resident's room. The 2 CNA's listed above exited the residents' rooms they assisted others from the dining room.

c. 12:48 p.m. - An unknown male CNA assisted a separate resident to her room and walked past the resident's room without responding to the resident's call light.

d. 12:52 p.m. - Staff A walked past the resident's unanswered call light.

e. 12:55 p.m. - A male dietary staff member and an unknown staff member walked past the resident's unanswered call light.

f. 12:56 p.m. - A male agency staff member walked a separate resident down the hallway and past the resident's activated call light.

g. 12:58 p.m. - Staff B, CNA propelled a female resident past the resident's unanswered call light.

h. 12:59 p.m. - An unknown female CNA answered the resident's call light, removed a room tray but did not shut off the call light.

i. 1 p.m. - The unknown female CNA returned to the resident's room and shut off the call light at

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1:03 p.m.

2. The Minimum Data Set (MDS) assessment dated 5/4/18, indicated Resident #7 had diagnoses that included diabetes mellitus (DM), cerebrovascular accident (CVA), hemiplegia, edema and chronic pain syndrome. The assessment documented she had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact memory and cognition. Resident #7 required the assistance of one staff with transfers and toilet use and did not walk.

During an interview 7/23/18 at 1:15 p.m. Resident #7 stated she timed her call light on as long as 1 hour using her watch which caused her not to feel very good. Additionally, the resident stated there had been times staff left her on the toilet for a lengthy period of time especially over the lunch hour which caused her pain.

3. The MDS assessment form dated 5/11/18 indicated Resident #8 had diagnoses that included urge incontinence, constipation, overactive bladder and edema. The assessment indicated the resident had a BIMS score of 15, she required the assistance of one staff with transfers, dressing and toilet use and did not walk.

During an interview 7/23/18 at 1:15 p.m. Resident #8 stated her call light would be on for lengthy periods of time due to a lack of staff. However, the resident failed to time how long her call light had been on at various times.

4. The MDS assessment dated 6/26/18 indicated Resident #1 had diagnoses the included a urinary

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tract infection (UTI), DM, chronic kidney disease, stage 4 (CKD) and insomnia. The assessment indicated she had a BIMS score of 12 out of 15, which indicates moderate cognitive and memory impairment. Resident #1 required the assistance of one staff with bed mobility, transfers and toilet use, did not walk and experienced occasional incontinence of her bowels and bladder.

During an interview 7/24/18 at 1:34 p.m., Resident #1 stated staff failed to answer her call light timely because of the lack of enough staff. The resident stated she timed the call light on up to 1/2 hour using the clock on the wall so she just peed the bed which felt dirty.

5. The MDS assessment dated 6/8/18 indicated Resident #5 had diagnoses that included hypertension (high blood pressure), CVA, Non-Alzheimer's dementia, closed fracture of the left lower radius (wrist), disorientation and tinnitus (ringing in the ears). The resident had a BIMS score of 10 out of 15, which indicated moderate cognitive and memory impairment. Resident #5 required the assistance of one staff with transfers, walking, dressing and personal hygiene. The assessment indicated Resident #5 had range of motion impairment in one shoulder, elbow, wrist and/or hand.

A Physician's Progress Notes dated 5/22/18 at 9 a.m. documented the resident reduced her fluid intake due to having to go to the bathroom and often having had to wait for someone to answer the call light. Unfortunately, a lack of mobility and decreased fluid intake increased CVA risk factors.

During an interview 7/23/18 at 4:45 p.m. the resident and a family member confirmed the

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resident timed her call light on as long as 47 minutes using the clock on the wall. The delay made her felt like exploding due to the need to urinate and also caused anger. The resident stated she quit drinking a lot of water because staff failed to answer the call light in a timely manner.

6. The MDS assessment dated 5/11/18 indicated Resident #9 had diagnoses that included unspecified abdominal pain, polyosteoarthritis and generalized muscle weakness. The assessment documented a BIMS score of 15. The assessment indicated the resident suffered from constant pain which made it hard to sleep at times and limited her day to day activities. On a scale of 0-10, the resident rated her worst pain at a 6.

During an interview 7/25/18 at 10:28 a.m., Resident #9 stated she utilized the call light system and timed the light as on for up to 2 hours as she watched the clock on the wall. The resident stated she used the call light to ask for pain pills and suffered from terrible pain while she waited for pain pills.

During an interview 7/25/18 at 10:22 a.m., Staff F, Licensed Practical Nurse (LPN) stated Resident #9 called the nurse's station for staff assistance.

7. During a resident Group interview on 7/25/18 at 11:48 a.m., 4 of 6 residents stated that staff failed to answer their call lights within 15 minutes or less due to not enough staff.

8. Review of the Resident Council Meeting minutes revealed the following information as dated:

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a. 7/6/17 - Call lights not answered in a timely manner.
b. 8/3 - Call lights not answered in a timely manner.
c. 9/7 - Call lights not answered in a timely manner.
d. 4/5/18 - Residents requested their call lights answered quicker.
e. 5/3 - Call lights not answered all the time on hall 2.
f. 6/7 - Call lights took long to answer on halls 1, 2 and 3.

During an interview 7/24/18 at 2:19 p.m., Staff B, Certified Nursing Assistant (CNA) indicated staff were not really able to answer call lights timely and residents complained at times.

During an interview 7/24/18 at 3:21 p.m., Staff C, CNA indicated she answered resident call lights the best she could but it depended on the situation. Staff C could not say she answered all resident call lights in 15 minutes or less.

During an interview 7/25/18 at 12:33 p.m., Staff D, CNA indicated her ability to answer resident call lights timely depended on if she took care of other residents or not; then it may take longer. Staff D confirmed residents complained about call lights not being answered timely.

During an interview 7/25/18 at 2:12 p.m., Staff G, Certified Medication Aide (CMA) indicated there had been a couple of call lights on over 15 minutes and he has heard residents complain here and there.

During an interview 7/25/18 at 2:30 p.m., Staff A,

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F 725	Continued From page 32 CNA indicated he could not always answer call lights in 15 minutes or less but that he tried his best	F 725		