STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175221	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOUNTAINVIEW NURSING & REHAB CENTER	**601 N ROSE HILL ROAD ROSE HILL, KS 67133**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 42 residents, with four residents included in the sample. Based on observation, interview and record review, the facility failed to ensure preventative measures to prevent the development of pressure ulcers including a bed cradle and Prevalon boots (a brand of preventative boots to relieve pressure) remained in place for one of the four sampled residents, Resident (R) 3. Findings included: - The signed Physician order [REDACTED]. The Annual Minimum Data Set (MDS), dated [DATE], documented the resident admitted [DATE]. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 09, indicating he had impaired cognition. The resident's functional status documented the resident needed total assistance with bed mobility and transfers. He had no pressure ulcers but was at risk. The care plan, dated 06/19/2020, documented the resident had a self-care deficit for ADLs (activities of daily living). The staff were to apply Prevalon (a brand of preventative boots to relieve pressure) boots to the resident's feet at night and when in bed. On 05/27/2020 the resident was to have a foot cradle used on his bed. The POS, dated 08/03/2020, evidenced the resident was to have bilateral heel protectors on while in bed. Observation, on 08/03/2020 at 11:15 AM, revealed the resident lying in bed without the pressure relieving boots on his feet. The boots lay on top of the covers. Observation, on 08/03/2020 at 11:30 AM, revealed the boots remained on top of the covers. Observation, on 08/03/2020 at 11:47 AM revealed Licensed nurse H completed an assessment of the resident's toes. The left great toe was clear of any open wounds. The left second toe noted with a 1 cm (centimeter) by 2 cm superficial area without depth. The left fifth toe noted almost closed with a 1 cm by 0.5 cm superficial area without depth. Observation, on 08/03/2020 12:05 PM, revealed the resident was lying in bed with his feet uncovered with only socks on his feet and without a bed cradle. The pressure relieving boots lay on the floor next to the bed. Observation, 08/03/2020 at 2:24 PM, revealed the resident lying in bed with the head of bed slightly elevated, leaning slightly to the left with his eyes closed. The Prevalon boots were sitting on the overbed table. On 08/13/2020 at 12:22 PM, Certified Nurse Aide (CNA) N reported the resident was totally dependent with bed mobility and transfers. When he was assisted to bed, he probably should have the boots on. On 08/13/2020 at 12:25 PM, CNA M reported, when the resident was laid down after meals, he wears those big soft foam type boots while in the bed, he wears soft shoes while up. CNA M further reported he had areas on his toes and can't wear shoes. On 08/13/2020 at 12:17 PM, CNA O reported the resident needs help to lay down in the bed and staff had to make sure he had those boots on his feet. They prevent pressure. He does not have a bed cradle. On 08/13/2020 at 12:35 PM Licensed Nurse G reported during the day, when out of bed, the resident wore non-skid socks or soft house slippers. When he was in the bed, he wore boots that prevent pressure. The resident should always have those on when in the bed. He also always used a bed cradle while in bed. On 08/13/2020 at 12:39 PM, Administrative Nurse D reported he had areas on two of his toes on his left foot. The care plan interventions included pressure relieving boots in bed, as needed and as tolerated. The resident might kick them off and if the staff would find them on the bed or the floor, staff should replace them and try to get him to wear the boots. Nurse D further stated the care plan does say he should have a bed cradle and wear the boots. The policy titled Using the Care Plan, revised August 2006, directed the nurse supervisor used the care plan to complete the CNAs daily work assignment sheets and or flow sheets. The policy titled Wound Care, revised October 2010, directed staff to review the resident's care plan to assess for any special needs of the resident. The facility failed to ensure the placement of the protective pressure relieving boots or the bed cradle, while the dependent resident was lying in the bed, to prevent further breakdown and promote healing of the pressure areas on his toes.

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

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