| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165484 | A. BUILDING _____ B. WING _____ | 10/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKE LUTHERAN NURSING HOME | 1301 SAINT LUKE DRIVE SPENCER, IA 51301 |

| (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<br><br>Correction Date: _____<br><br>The following deficiencies are the result of the recertification survey completed 10/16-19/17.<br><br>(See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.) | F 000 | | |
| F 314 SS=G | 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>(b) Skin Integrity -<br><br>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(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<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, staff interview, and facility policy, the facility failed to assure residents received care, consistent with professional standards of practice, to prevent pressure ulcers, promote healing, and prevent new ulcers from developing for 2 of 4 residents reviewed (Residents #1 and #11); and failed to notify a physician in regards to a deteriorated | F 314 | | |

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 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 314 | Continued From page 1 | F 314 | | |

pressure ulcer for 1 of 4 residents with pressure ulcers reviewed (Resident #2). The facility reported a census of 85 residents.

Findings include:

1) A Care Area Assessment (CAA) dated 5/11/17 regarding pressure sores documented Resident #1 had a high risk for a heel ulcer.

A Care Plan Goals form dated 5/11/17 documented Resident #1 may have skin breakdown or pressure ulcers (including heel ulcers) because of diabetes, edema, impaired circulation and incontinence.

A list of care plan interventions showed the intervention to use heel protectors to both Resident #1's feet while in bed initiated 5/9/17.

According to the Minimum Data Set (MDS) assessment, dated 8/4/17 Resident #1 demonstrated long and short term memory problems and moderately impaired skills for daily decision making. Resident #1 required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, dressing, toilet use, and bathing. Resident #1's diagnoses included renal failure, diabetes, and Alzheimer's. Resident #1 had a risk for developing pressure sores, but had no pressure sores.
The MDS defined a Stage 1 pressure ulcer as intact skin with non-blanchable redness of a localized area. A Stage 2 area as partial thickness skin loss of dermis presenting as a shallow crater with a red or pink wound bed without slough, or an intact or open/ruptured serum filled blister. An unstagable pressure ulcer is a known ulcer but not stageable due to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165484 | A. BUILDING _____ B. WING _____ | 10/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 314 | Continued From page 2 | F 314 | | |

coverage of wound bed by slough/eschar (dead tissue).

A Braden Scale dated 9/19/17 scored Resident #1 at 14 indicating moderate risk for skin breakdown.

A hospital Discharge Summary documented Resident #1 admitted 9/18/17 and discharged 9/22/17. Resident #1 had a history of CHF and type 2 diabetes. Resident #1 was getting more short of breath and gain 10-15 pounds of weight and appeared to be in an exacerbation of her congestive heart failure (CHF). Resident #1's diagnoses included acute congestive heart failure on top of chronic congestive heart failure.

A Readmission assessment dated 9/22/17 at 1:02 p.m. documented Resident #1 arrived from the hospital at 11:39 a.m. Resident #1 experienced weakness, and transferred with the mechanical lift and 2 assist. Skin problems noted on the readmission did not include any concerns with the heels.

Resident Bruise/Skin Tear Injury Reports dated 9/25/17 documented Resident #1 had a fluid filled blister on the the right heel measuring 7 by 4.6 cm., and had a red, soft (left ) heel.
A Incident Report dated 9/25/17 at 11:25 a.m. documented Resident #1 had a blister, possibly caused by shoes with an insole causing a seam at the heel while in the recliner.

A hand written note by Staff F Registered Nurse (RN) dated 9/25/17 documented on reviewing the incident, Resident #1 noted with a fluid filled blister on the right heel, and slightly soft left heel. The resident could not say how it occurred, and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165484 | A. BUILDING _____ B. WING _____ | 10/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 314 | Continued From page 3 | F 314 | | |

denied pain. Resident #1 had a BIMS of 5 (severely impaired cognition) and diagnoses of diabetes, Alzheimer's dementia, and intellectual disabilities. He/she took Lasix and spironolactone which can affect the skin. He/she had a care plan intervention to wear bilateral heel protectors when in bed, but had no heel protectors in his/her room. The Certified Nursing Assistants (CNA's) were provided with a mini inservice to use heel protectors. The care plan not updated, due to non-use of heel protectors. An addendum on 10/13/17 documented the care plan was not followed.

Two Mini-Inservice forms dated 9/25/17 regarding 6 p.m. to 6 a.m. shift 9/23/17 and 9/24/17 documented a diabetic resident care planned for heel protectors on both feet while in bed. Resident developed a blister and no heel protectors in his/her room 9/25/17 when blister noted.

During an interview on 10/18/17 at 4:05 p.m. Staff F stated they had no boots in Resident #1's room on 9/25/17. One of the CNA's signed the mini inservice form and stated she didn't know Resident #1 needed to wear boots. The other CNA did not sign the form. She heard the CNA wrote a note about it, but did not know what it contained.

During an interview on 10/18/17 at 4:15 p.m. the Director of Nursing (DON) stated the other CNA said she did not put the protective boots on (9/23-24/17) because the resident was not care planned for boots. The DON confirmed the boots were on the care plan.

Care Plan Change Alerts notified staff of the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165484 | A. BUILDING _____ B. WING _____ | 10/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 314 | Continued From page 4 | F 314 | | |

addition of care plan interventions:
a. 9/25/17 No shoes until blister resolved, wear slipper socks, skin prep right heel until resolved, left heel every day. Assure bilateral heel protectors are on in bed.
b. 9/26/17 Waffle boot right leg at all times, heel protector to left heel at all times, and continue no shoes until resolved.

A fax dated 10/3/17 notified the physician Resident #1's right heel blister revealing a 3 by 2.4 cm reddened area with dark purple/black 0.8 by 3.2 cm with a moderate amount of serous drainage. Non-adherent dressing placed initially, and the current treatment skin prep 2 times a day until healed. Waffle boot on at all times, please advise. The physician responded to consult wound nurse for evaluation and treatment.

In a report dated 10/5/17 the wound nurse documented Resident #1 referred for bilateral heel pressure ulcers. The left heel a stage 2 pressure ulcer, with a blister measuring 4 by 2.7 cm. The periwound (surrounding skin) had slight erythema (redness). They would continue with skin prep and keep heels up. The right heel blister with deep tissue injury. The area measured 6 by 4.2 cm. The blister starting to deflate with serous exudate (drainage). Dark purple discoloration at the center measuring 3 by 1 cm. They would continue with skin prep and keep covered with telpha and kling, and continue EHOB (to reduce pressure) boot to keep heels pressure free.

A significant change Dietary Note dated 10/9/17 lacked any documentation of Resident #1's pressure ulcers or nutritional needs related to them.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165484 | A. BUILDING _____ B. WING _____ | 10/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 314 | Continued From page 5 | F 314 | | |

During an interview on 10/17/17 at 11:20 a.m. Staff E MDS Coordinator stated she did not know if the dietician assessed Resident #1's nutritional needs. At 11:30 a.m. Staff E stated the dietician had not addressed the pressure ulcers, and did not know if the Dietician had been notified of the pressure ulcers.

On 10/18/17, the dietician informed the physician in a note: due to Resident #1's current ulcer, [she] does have increased protein needs and recommended Beneprotein BID with lunch and supper.

A follow-up on bilateral heel pressure ulcers dated 10/12/17 documented the right heel with an unstagable ulcer. Loose skin from the blister conservatively removed with pickups and scissors. Black eschar noted under the blister measuring 3 by 1 cm. The periwound skin denuded measuring 7 by 4.5 cm. Left heel pressure ulcer, a deflated blister measured 4 by 3 cm with the area drying. New dressing orders received for the right heel and recommended waffle boots bilaterally at all times.

Care Plan Change Alerts notified staff of the addition of care plan interventions:
c. 10/11/17 bilateral waffle boots at all times, free float heels at all times (including a picture showing a pillow under the legs, not under the heel).
d. 10/12/17 discontinue heel protectors. Waffle boots bilaterally at all times.

During an observation on 10/17/17 at 1:25 p.m. Staff C RN and Staff D RN provided treatment of Resident #1's heel ulcers. The right heel had

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165484 | A. BUILDING _____ B. WING _____ | 10/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ST LUKE LUTHERAN NURSING HOME | 1301 SAINT LUKE DRIVE SPENCER, IA 51301 |

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|---|---|---|---|---|
| F 314 | Continued From page 6 | F 314 | | |

black eschar measuring 2.5 by 1.4 cm and the red open area surrounding it measured 4 by 2.5 cm. The left heel ulcer measured 3.5 by 2 cm brown tissue.

During an observation on 10/18/17 at 10:32 a.m. Resident #1 sat in the recliner (by the nurse's station) with a pillow under his/her heels. Staff B Registered Nurse (RN) readjusted Resident #1's waffle boots and pillow so his/her heels free floated, after confirming they were not free floating.

During an interview on 10/18/17 at 8:40 a.m. Staff E stated they did not (initially) do the waffle boot on the left foot because (the heel) was just red and blanchable. It did become a Stage 2 and they put waffle boots on both heels (6 days after the wound nurse documented a blister and staged the left heel at a 2). She said they had communication sheets they put out when there were intervention changes (see care plan change alerts previously documented). She said staff were educated when areas developed for not using the heel protectors as care planned. On 10/19/17 at 8:50 a.m. Staff E confirmed Resident #1 did not have a specialty mattress on his/her bed. She said Resident #1 had a standard pressure reduction mattress.

During an interview on 10/18/17 at 7:25 a.m. the Dietician stated they did not make her aware of Resident #1's pressure ulcers until yesterday. She stated she would have assessed Resident #1's needs for increased protein/nutrition.

A fax dated 10/18/17 notified the physician Resident #1 had increased protein needs due to pressure ulcer. The Dietician recommended 4

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165484 | A. BUILDING _____ B. WING _____ | 10/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKE LUTHERAN NURSING HOME | 1301 SAINT LUKE DRIVE SPENCER, IA 51301 |

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|---|---|---|---|---|
| F 314 | Continued From page 7 | F 314 | | |

ounces liquid with 1 scoop Beneprotein 2 times a day with lunch and supper. Dietary staff updated on protein requirements and would offer protein pancakes with a side of eggs at breakfast.

The facility policy, Prevention of Pressure Ulcers reviewed 8/15/15 identified the risk factor of immobility and included when in bed every attempt should be made to float heels by placing a pillow from knee to ankle or with other devices as recommended by clinical staff or by the physician.

The facility policy, Pressure Ulcer Risk Assessment reviewed 8/15/15 documented because a resident can develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at risk residents need to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers.

2). According to the MDS assessment, dated 6/9/17 Resident #11 scored 7 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Resident #11 required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, dressing, toilet use, and bathing. Resident #1's diagnoses included renal failure, diabetes, and Alzheimer's. Resident #11 had a risk for developing pressure sores, but had no pressure sores.

A facsimile dated 8/2/17 notified the physician Resident #11 readmitted to the facility with a reddened coccyx and bilateral buttocks. The coccyx had a Duoderm on to change 3 times a week. Resident #11 had 2 small open areas to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165484 | A. BUILDING _____ B. WING _____ | 10/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKE LUTHERAN NURSING HOME | 1301 SAINT LUKE DRIVE SPENCER, IA 51301 |

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|---|---|---|---|---|
| F 314 | Continued From page 8 | F 314 | | |

the left hip covered with polymem and tape to change 3 times a week. Bilateral heels were pink.

The wound nurse saw Resident #11 on 8/10/17 with recommendations.

A progress note dated 10/6/17 documented Resident #11's return from the hospital, from an admission on 9/28/17 for pneumonia. An initial assessment on readmission documented pressure ulcers on admission:
a. Right mid buttock redness measuring 0.6 by 0.4 cm stage 2 pressure ulcer.
b. Penile meatus with 0.5 by 0.9 cm open ulcer with a white/yellow base.
Other skin conditions:
a. Left heel, slightly mushy, red intact.
b. Right heel mushy intact.
c. Entire scrotum red and edematous.
d. Dorsal scrotum with 0.4 by 0.2 cm open area with white/yellow base, and 0.8 by 0.3 cm open area present anterior to the other area.
e. Left buttock 13 by 4 cm reddened.
f. Right mid buttock reddened 6 by 3.4 cm.

The wound nurse saw Resident #11 on 10/12/17 with recommendations.

The most recent dietary assessment found for Resident #11 was done on 6/9/17.

During an interview on 10/19/17 at 7:55 a.m. the Dietician stated she was not aware of Resident #11's skin issues, and she would have assessed nutritional status if she had known.

The facility policy, Prevention of Pressure Ulcers reviewed 8/15/15 identified nutrition. The policy

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165484 | A. BUILDING _____ B. WING _____ | 10/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKE LUTHERAN NURSING HOME | 1301 SAINT LUKE DRIVE SPENCER, IA 51301 |

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|---|---|---|---|---|
| F 314 | Continued From page 9 | F 314 | | |

indicated the dietician would assess nutritional status and hydration and make recommendations based on the individual resident assessment. Lab values would be monitored. Administer vitamins, minerals and protein supplements in accordance with physician orders and dietician recommendations.

3. According to a Diagnosis List, Resident # 2's diagnoses included dementia, cardiac arrhythmia, atrial fibrillation, chronic kidney disease, thrombocytopenia and history of malignant neoplasm of prostate.

A Minimum Data Set (MDS) assessment with a reference date of 9/29/17, documented Resident #2's Brief Interview Mental status (BIM's score) as an 8, indicating moderate impairment in his/her mental status. The MDS revealed the resident required extensive assistance from staff with bed mobility, transfer, toilet use and personal hygiene and assessed the resident with a Stage 2 pressure ulcer. The MDS identified the resident's admission to the facility as 8/22/17.

Review of a skin assessment dated 8/22/17, revealed the resident had a Stage 1 pressure ulcer on his/her coccyx area. Staff described the area as intact skin, with a 5 by 3 centimeter (cm) deep redness on each inner buttock and an approximate 1 cm of attached rolled skin in the center of the redness. The assessment documented a Mepilex dressing, without tape, covered the area.

A Braden Scale (assessment to predict pressure sores) form dated 8/22/17 , revealed staff assessed the resident to be at high risk for skin

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165484 | A. BUILDING _____ B. WING _____ | 10/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKE LUTHERAN NURSING HOME | 1301 SAINT LUKE DRIVE SPENCER, IA 51301 |

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|---|---|---|---|---|
| F 314 | Continued From page 10 | F 314 | | |

breakdown.

Resident #2's Care Plan, dated 9/1/17, included a problem for a Stage 1 pressure ulcer. The Care Plan included approaches to look at and record the resident's ulcer weekly and let a Physician know if the ulcer got worse or not healing. The Care Plan included an update 10/10/17 with a problem for a Stage 2 pressure ulcer. The approach remained on the care plan to let the Physician know if the pressure ulcer got worse or failed to heal.

A facsimile to a Physician dated 8/22/17 (same day as admission to the facility), revealed staff requested the resident's dressing cover over his/her coccyx pressure ulcer be changed from a Mepilex dressing PRN (whenever necessary) to a Duoderm dressing change on bath days (2 times a week) and PRN until healed.

According to a facility Pressure Ulcer Treatment form with a review date of 8/15/15 a description of a Stage 1 pressure ulcer included an intact non-blanchable redness, usually over a bony prominence and a description of a Stage 2 pressure ulcer included a partial thickness loss of dermis presenting as a shallow open ulcer with a pink wound bed, without slough.

Review of weekly skin assessment forms revealed the following:

9/1/17 at 5:52 P.M.- Reddened areas left and right inner buttocks bilaterally. Each area measured the same at 0.9 by 0.3 cm. Staff also noted an open area to his/her bilateral buttock.

9/8/17 at 9:03 P.M.- Staff documented the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165484 | A. BUILDING _____ B. WING _____ | 10/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST LUKE LUTHERAN NURSING HOME | 1301 SAINT LUKE DRIVE SPENCER, IA 51301 |

| (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 | F 314 | | |

resident refused any type of assessment and told staff the assessment could be done in the morning. Review of skin assessment forms revealed staff failed to attempt to assess the resident's coccyx area until 9/15/17.

9/15/17 at 9:20 P.M. - Left upper buttock and right upper buttock coccyx measured 0.4 by 0.2 cm. Staff documented the area as healing with fragile tissue noted in the base of the open area.

9/22/17 at 4:10 P.M.- Left upper buttock and right upper buttock coccyx, area is reddened around edges, granulation continues in base, measured 1.4 cm by 0.4 cm and worsening.

9/26/17 at 5:36 P.M. - Left upper buttock and right upper buttock coccyx measured 1.7 cm by 0.3 cm., granulation continues in base.

10/4/17 at 1:46 A.M. - Coccyx ulcer measured 2 by 0.2 cm., staff described the area as moist and light /pale pink in color.

10/6/17 at 10:14 P.M. - Open area on the left upper buttock and right upper buttock, measured 1.9 by 0.3 cm and granulation continued in the base.

10/10/17 at 11:29 P.M. - Coccyx ulcer measured 2.2 by 0.2 cm.

10/13/17 at 8:08 P.M. - Open area left upper buttock and right upper buttock measured 1.9 by 0.2 cm.

(Note: During interview on 10/19/17 at 8:00 A.M., the facility Director of Nursing confirmed the times of the skin assessments completed above

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165484 | A. BUILDING _____ B. WING _____ | 10/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ST LUKE LUTHERAN NURSING HOME | 1301 SAINT LUKE DRIVE SPENCER, IA 51301 |

| (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 | F 314 | | |

outside of normal sleep hours re: 11:29 P.M., 1:46 A.M. etc, were documented at the time the nurse documented the skin assessment rather than the time the skin assessment was completed).

The resident's pressure ulcer changed from a closed Stage 1 ulcer to an open Stage 2 ulcer and the facility failed to notify the resident's Physician of the change.

Review of a Client Coordination Note Report dated 10/14/17, revealed Resident #2 was admitted to Hospice Services.

Review of a facsimile to Hospice services dated 10/17/17, revealed nursing staff advised the Hospice staff of the measurements of the resident's coccyx pressure ulcer as 1.9 cm by 0.2 cm and 0.1 cm in depth.

A facility Pressure Ulcer Risk Assessment form, with a review date of 8/15/15, included direction for staff to document in the medical record Physician notification if noted a new skin alteration with a change in the plan of care.

During interview on 10/17/17 at 1:30 P.M., Staff A, MDS Registered Nurse, stated she notified the facility wound nurse assigned to completed Resident #2's skin assessment and the skin nurse confirmed she had not notified the resident's Doctor in regards to the change in the resident's coccyx pressure ulcer.

During interview on 10/17/17 at 3:00 P.M., Staff A confirmed she expected nurses to notify a Resident's doctor if assessed a change in a Resident's pressure ulcer.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165484 | A. BUILDING _____ B. WING _____ | 10/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ST LUKE LUTHERAN NURSING HOME** | **1301 SAINT LUKE DRIVE SPENCER, IA 51301** |

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