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	165484	A. BUILDING _____ B. WING _____	02/07/2019

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ST LUKE LUTHERAN NURSING HOME	1301 SAINT LUKE DRIVE SPENCER, IA 51301

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F 000	INITIAL COMMENTS Correction date: 3-10-19 A recertification survey and investigation of facility reported incident #77014-I completed 2/4-7/19 resulted in the following deficiencies. Self reported incident #77014 was substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the facility of the truth or conclusions set forth in the statement of deficiencies. In the spirit of cooperation with CMS guidelines, the facility submits the following as a credible plan of correction for compliance with all deficiencies stated. All deficiencies will be completed 3/10/2019 except for F689 which was corrected 2/8/2019.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to resubmit a level 1 PASRR (Preadmission Screening and Resident Review) when additional mental health diagnoses	F 644	The facility coordinates assessments with the pre-admission screening and resident review (PASRR) program under Medicaid Part C of this part to the maximum extent possible to avoid duplicative testing and effort by incorporating the recommendations from PASRR Level 2 determination and evaluation report into resident assessment, care planning, and transitions of care and referring with newly evident or possible serious mental disorder, ID, or related condition for Level 2 resident review upon a significant change in status assessment. For the residents identified on 2567 they had new PASRR submitted while the surveyors were in the building and approached if necessary were placed in the resident care plans. The Director of Health Services reviewed all residents, sought diagnosis clarifications and submitted new PASRR request to those affected residents. The Director of Health Services or Social Service Director or designee will review and monitor all current residents and readmission for changes in medical history including psychotropic medication (unless doing a taper up or down or doing adjustment to see what is effective for the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn K West	CEO/Admin	03/10/2019

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 644	Continued From page 1 were added for 2 of 6 resident identified for review of PASRR. (Resident #10 and #64). The facility reported a census of 82 residents. Findings include: 1. Resident #10's PASRR dated 3/15/17 documented the resident did not have any mental illnesses. Resident's most recent MDS (Minimum Data Set) dated 11/09/2018 listed mental health diagnosis of anxiety and depression. A Physician's progress note dated 12/23/18 identified diagnosis included Major Depressive Disorder, single episode, mild. Resident's Care Plan dated 11/13/18 included approaches directing staff to assess for behavior changes, signs and symptoms of depression, and to monitor for side effects of the medication Zoloft (anti-depressant) that resident takes daily for anxiety. 2. Resident #64's PASRR dated 01/22/2018 documented the resident did not have any mental illness. Physician's orders dated 1/4/19 listed a mental health diagnosis of Major depression disorder, single episode, unspecified. Resident's most recent MDS (Minimum Data Set) dated 01/04/2019 listed mental health diagnosis of depression. A mental health note dated 9/20/2018 assessed Major depressive disorder, single episode, unspecified and Dementia with behavioral disturbance including delusions and paranoia.	F 644	resident) and mental illness with updates accordingly with any new or changed diagnosis. Updating PASRR will occur at the time of change and will be reviewed quarterly or with significant change MDS to ensure all appropriate diagnosis and medications are reported on the PASRR. The Director of Health Services or designee will report to the QAPI committee the status of PASRR no less then quarterly. QAPI director will monitor PASRR randomly x 3 months for compliance and then as needed for continued compliance.	

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F 644	Continued From page 2 Resident's Care Plan dated 1/8/2019, included approaches directing staff to assess/monitor for behavior changes (includes agitation, anxiety, aggression,delusions, hallucinations, and or decreased inhibitions) and to assess for signs/symptoms of depression. In an interview on 2/6/19 at 10:15 AM, the Director of Nursing (DON) acknowledged that the facility could not provide resubmission of Level 1 PASRR's on Resident's #10 and #64's as the facility had not done them. The facility failed to submit a new level 1 PASSR after mental health diagnosis were added.	F 644		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide adequate supervision to prevent accidents for 1 of 4 residents reviewed (Resident #133). Resident #133 had a history of falls with injury. Staff interview revealed staff had knowledge the resident could shut of her motion sensor alarm, but failed to inform the director of nursing, which would have allowed additional fall interventions to be put into place. to prevent further falls. The resident transferred/ambulated	F 689	The facility provides an environment that is free from accident hazard over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. Resident #133 expired due to multiple comorbites and dementia. For all other residents the following were implemented: 1. Shift huddles were held following the fall and education was provided on the use of alarms. 2. An alarming device assment was in use. 3.Alarming devices were reduced to minimal use of them, and encouragement/education was given to families that alarms do not prevent falls, but in fact can increase the risk for falls. 4.On 7/18/19 a memo was presented to all nursing staff to review and acknowledge on fall prevention (which was given to surveyor during the survey). 5. A fall prevention inservice was held 8/8/2018 on Fall Prevention. (given to surveyor	

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F 689	Continued From page 3 independently, fell and sustained a head laceration and a fractured hip. The motion sensor was not on. The facility reported a census of 82 residents. Findings include: According to the Minimum Data Set (MDS) Assessment dated 5/11/18 Resident #133 scored 8 on the Brief Interview for Mental Status (BIMS) indicating cognitive impairment. The resident required limited assistance with activities of daily living (ADL's) including bed mobility, transfer, ambulation toilet use and personal hygiene. The resident had 2 falls with no injury and 1 fall with a minor injury. An Incident Report dated 5/27/18 at 8:15 PM documented the resident fell in her room. The resident took her shoes off getting ready for bed. A Diagnostic Imaging report dated 5/28/18 documented the findings from an x-ray included the resident had left rib fractures, likely rib 7 and 8, possibly including rib 6 as well. An Incident Report dated 6/4/18 at 1:30 PM documented the resident fell in her room when transferring without assistance. The resident sustained no apparent injury. An Incident Report dated 6/4/18 documented the resident had a laceration found at 5:50 PM. A Nursing Home to Hospital Transfer Form dated 6/4/18 documented the reason for the transfer a gash to the back of the head and goose egg from a fall. A hospital report dated 6/4/18 documented the	F 689	during survey). 6. A skills fair was held August 15, 16 and 17th 2018. During this fair hourly rounding was reviewed, prevention of falls was discussed, the clinical protocol was reviewed, and transferred techniques were evaluated. No falls have occurred since that time due to the use of an alarm and the resident shutting it off or removing it. Staff were given a memo as a reminder that will no longer be used and the few in the building will be eliminated as we are able. Risk/ Benefit statements are placed in regards to the alarm. Staff were instructed that if they know an alarm is being shut off or removed, they must notify the charge nurse immediately for a different action to be placed and the alarm removed. An inservice will be held 3/6/2019 with reminders to the above. Continuing monitoring of falls will occur as they happen. Falls will be reviewed with weekly Medicare Meetings and discussed during QAPI. The QAPI Director, DON, and Nursing Supervisor will continue to monitor falls as they occur and will discuss interventions with staff for the prevention of falls. The MDS nurses will continue to monitor residents for risk for falling and educating families risk and benefit using alarms at least quarterly or with significant change to MDS.	

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F 689	Continued From page 4	F 689		

resident's after care instructions regarding a laceration included to keep the wound clean and dry. May shower and wash hair but do not scrub too hard over the staples, place ice as needed, follow up with family doctor in 7-10 days to have staples removed.

An Incident Report dated 6/9/18 at 6:15 PM documented the resident fell in her room transferring without assistance, with no apparent injury.

A document dated 6/11/18 reviewing the incident documented the care plan was updated to have a motion sensor alarm when in her room, take the resident to the toilet before and after meals, and allow time for a bowel movement.

A Physician Visit report dated 6/12/18 documented the resident seen for status post head laceration sustained 6/4/18 with staples placed in the emergency room. The progress note documented the resident to have staples removed from scalp laceration and the nurses also noted she had increased confusion and anxiety lately.

The Care Plan dated 11/9/17 identified the resident at risk for falls. The interventions included a motion sensor when in room for safety, offer toilet every 2-3 hours while awake, take to the bathroom before and after meals, and allow time for a bowel movement.

An Incident Report dated 7/7/18 at 6:30 PM documented the resident fell in her room self transferring, the motion sensor off.

A CNA Quality Assurance Fall and Injury

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F 689	Continued From page 5 Assessment dated 7/7/18 documented the resident had a fall and found lying on the left side with blood on the floor. The resident self transferred and the motion sensor not on. A History And Physical dated 7/7/18 documented the resident fell and hit her head sustaining a laceration. She had a lot of pain in the left hip. An x-ray revealed an intertrochanteric fracture of the left hip. The scalp laceration repaired in the ER. Orthopedics recommended admission and surgical intervention. A Consultation report dated 7/8/18 documented the recommendations included surgical stabilization to facilitate ambulation and pain relief. The resident had a high risk of morbidity (medical problems) due to the fracture. Leaving her without surgery would likely leave her with worse outcomes and pain. A Discharge Summary dated 7/12/18 documented the resident fell at the nursing home and found to have a left hip fracture. The resident was post-op day 4 from a left hip short gamma nail for fixation. The resident disoriented to time and place. The resident refused most medications by mouth and resisted feeding. The resident tolerated Roxanol for pain. Hospice care discussed. The resident had acute blood loss anemia in the setting of an open reduction and internal fixation of a left hip fracture. The resident's hemoglobin 9.9 on admit, dropping to 6.9 after surgery. The resident received 2 units of blood. A Physical Therapy (PT) Evaluation and Plan of Treatment dated 7/13/18 documented the resident unable to participate and not appropriate	F 689		

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F 689	Continued From page 6	F 689		

for PT. The resident unable to tolerate any activity and no restorative program indicated. The resident grimaced and yelled when the leg moved.

Nurse's Notes documented the following:
On 7/12/18 at 1:07 PM resident readmitted from the hospital. At 1:59 PM the resident did cry out and moan when touched or moved. At 4 PM the resident cried out when touched.

On 7/13/18 at 7:33 AM the resident received Roxanol for moaning. At 10:43 AM the resident received Roxanol for moaning and saying help me. At 11:26 PM the resident unable to rate pain due to cognitive function but moaning and given pain medication.

On 7/14/18 at 12:47 AM as needed pain med given. At 2:52 AM med ineffective, resident given another dose of Roxanol. At 9:24 AM resident given pain med for pain all over. At 11:48 AM Roxanol given for pain all over, moaning out. At 1:52 PM the resident received Roxanol for crying and moaning out. At 5:07 PM the resident received Roxanol for crying out. At 5:44 PM the resident admitted to hospice. At 7:32 PM Roxanol given for pain all over. At 8:03 PM Ativan given for crying out/restlessness. At 8:31 PM Roxanol given for pain. At 9:37 PM Roxanol given for pain all over. At 11:02 PM Roxanol given for pain all over.

On 7/15/18 at 12:22 AM the resident cried and repeated help me. The resident was restless and moaned with facial grimacing with any movement. At 2:44 AM Roxanol given for pain all over. At 3:53 AM Roxanol given for pain. At 4:51 AM Roxanol given for pain, resident began

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F 689	Continued From page 7	F 689		

crying/moaning with repositioning. At 9:34 AM Roxanol given for crying out. At 10:36 AM Roxanol given for pain/crying out. At 11:44 AM Roxanol given for crying out. At 1:17 PM hospice request to give Roxanol every 1 hour and Ativan every 2 hours to keep comfortable. Staff informed hospice nurse the resident rested comfortably and didn't see any agitation or restlessness. Hospice instructed to hold off on Ativan unless sees in need, but to keep up with Roxanol.

The Nurse's Notes dated 7/16/18 at 4:23 PM documented the resident died at 4:10 PM.

An Employee Counseling/Warning Report dated 7/7/18 documented Staff A Certified Nursing Assistant (CNA) received an oral warning with written notice related to the resident sustaining a fall in her room at 6:30 PM. The motion sensor was not sounding and turned off. The resident was having loose stools at assessment and the care plan not followed for taking the resident to the restroom after meals and the alarm not on.

During an interview by phone on 2/4/19 at 11:33 AM Staff A (no longer works at the facility) stated she was assigned to the resident's hall the day of the incident (7/7/18). She stated she had asked the resident if she needed to use the bathroom prior to supper. She took a tray to the room and the resident consumed very little. She asked her again if she needed the bathroom and she again said no. She was not sure what time she left the room but was sure she turned the alarm on. She said it was placed near the television (TV) and at an angle. She said it allowed the resident to move in the chair without setting it off, but if she got up it would sound. She said she walked by

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the resident's room numerous times after that and she was always in the recliner. She reported seeing the resident last when she went by her room with another resident. She said she did not hear an alarm go off, but not sure she would. She said the resident could shut the alarm off herself and staff were aware of it. She said she placed the alarm so it would not be in the resident's reach, but she could have walked a few steps and turned the alarm off. She said she had not heard the resident's alarm sound that shift. She stated she signed the write up because she doesn't like to argue so she just signed it.

In a written statement dated 7/7/18 Staff B, Registered Nurse (RN) documented the resident sat in her recliner when he walked by her room to go do a treatment in another room. When he came out from doing the treatment he heard the resident yelling for help. When he entered the room he saw the resident laying on her left side with her hand up to her head and blood on the floor. He looked at the motion sensor and the switch was in the center position. Additionally he wrote the alarm had sounded earlier in the day. He had seen the resident try to shut the alarm off before, and she laid right in front of the motion sensor.

During an interview on 2/4/19 at 1:27 PM Staff B stated he worked a 12 hour day shift and was getting ready to be off. He had a few treatments he needed to finish up and walked by the resident's room and she sat in the recliner. He went in the other resident's room and shut the door. He did not hear an alarm go off, but did not know if he would. He said the motion sensor alarms were softer. He said the resident did like to shut the alarm off herself and they had it sitting

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F 689	Continued From page 9 on a table out of reach. When they found her on the floor she was in the general direction of where the alarm sat, rather than toward the bathroom. During an interview on 2/5/19 at 6:05 AM Staff C, CNA stated he saw the resident in her recliner as he walked down the hall to the other resident's room. It did not appear she needed anything at that time. He did not see the aide working that hall as he walked down to the other resident's room. Not long after he assisted the other resident into bed he heard the nurse yelling for help. He said the resident was on the floor and the resident's alarm was not turned on. He stated he had no knowledge the resident would turn the alarm off herself. He stated the resident would stop if the alarm sounded and would wait for someone. He said the resident would never say no to going to the bathroom. He said he would not force her to go, he would just take her to the bathroom. During an interview on 2/5/19 at 6:34 AM Staff D, Licensed Practical Nurse (LPN) stated she started the (7/7/18) shift at 6 PM. She did not recall any alarms sounding. She went down A hall with the day shift nurse to look at a skin condition and they passed the resident's room. She sat in the recliner watching TV in no distress. After looking at the skin she went back to the nurse's station and the day shift nurse stayed to do a treatment. While at the nurse's station getting things ready she heard Staff B call her name. She went to the resident's room and she was on the floor. She could see she had a head laceration and would need to be seen in the ER. She said the resident had 3 diarrhea stools before the paramedics arrived. She said the resident could tell you if she needed to go to the	F 689		

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F 689	Continued From page 10 bathroom. She said if she had gone to the bathroom earlier, it probably would not have changed the fact she had the loose stools at the time and directly after the fall. She said she thought the resident had turned the alarm off before, but had not actually seen her do it. She had turned the alarm on herself and returned to find it off when no one else had been in the room. She said the alarm was sitting on the TV stand out of reach of the resident when sitting in the chair. She said it would have been about 3 steps away from the recliner and would have been in reach of the resident where she fell. She said she did write the staff member up, although the staff member said she had turned the alarm on. During an interview on 2/6/19 at 2:43 PM Staff E, RN, Nurse Manager stated she was unsure if the resident could shut the alarm off. She said if she could, they should have notified her so they could look at other interventions to prevent the resident from falling.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		

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F 880	Continued From page 11 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880	The facility established and maintains an infection control program that is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. For resident #283, isolation precautions were discontinued due to resolutions of infections. No further spread of C.Diff has occurred. For all similarly situated residents, nursing staff has taken CE Solutions inservice on C. Diff. A nursing staff meeting was held on 2/6/2019 on Infection Control and proper handwashing. The QAPI Coordinator or designee will monitor for appropriateness of handwashing randomly X 3 months and report to the QAPI Committee for compliance and then as the need arises. Education will be provided on a 1:1 basis to ensure continued compliance and as the need arises.	

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 _____	02/07/2019

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F 880	Continued From page 12 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to ensure staff followed infection control practices for 1 of 1 residents reviewed (Resident #283). The facility identified a census of 83 current residents. Findings include: The Diagnosis List sheet for resident #283, dated 1/29/2019 included diagnosis Enterocolitis (inflammation of the bowel) due to Clostridium difficile (bacteria) commonly referred to as C-diff. According to the resident's initial baseline care plan, the resident was admitted on 1-29-19 and in Isolation/quarantine for C-diff , the type of isolation identified as contact isolation. The Care Plan was updated 1/29/19 and further directed staff that the resident is on contact precautions and to glove and gown before entering room if contact with the resident, linens, toileting, etc may occur. Specifically directed staff to alcohol hands and put on gloves before entering room, if contact is expected and thoroughly wash and dry hands before leaving room.	F 880		

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F 880	Continued From page 13 This resident's Medication List dated 1/30/2019 shows Vancomycin (an antibiotic) ordered for this resident with a discontinuation date of 2/7/2019 for C-diff. An undated document titled, The Infection Control Guidelines for All Nursing Procedures, directed staff to wash their hands for ten to fifteen seconds using antimicrobial or no-microbial soap and water under the following conditions: When there is likely exposure to spores (i.e., C. difficile or Bacillus anthracis) and noted alcohol-based hand rubs are inactive against spores. For effective mechanical removal of spores, wash hands for 30-60 seconds with soap and water or 2% Chlorhexidine Gluconate. The undated policy titled Clostridium Difficile, identified steps toward prevention and early intervention included frequent handwashing with soap and water by staff and residents. This policy directed that Residents with diarrhea associated with C. difficile will be placed on Contact Precautions and directed Healthcare workers will wear gloves and gowns upon entering the room of a resident with C. difficile infection and will remove gowns and gloves prior to exiting room. This policy furthermore stated hand washing with soap and water is superior to ABHE, alcohol based hand sanitizer, for the mechanical removal of C. difficile spores from hands. Observation on 2/5/19 at 10:11 AM Staff F, Certified Nurse Aide (CNA), removed gown and gloves, disposed of them in the provided receptacle, then used McKesson premium hand sanitizer (70% alcohol based) prior to exiting the	F 880		

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F 880	Continued From page 14 resident's room. In an interview with Staff F immediately after observed leaving the resident's room revealed she had responded to the resident's activated call light, applied hand sanitizer, gown then gloved and entered the room. Further reported assisted the resident with transfer, toileting, peri care, and assisted the resident with getting dressed. Staff F confirmed she then removed the gown and gloves, disposed of them in the room and used hand sanitizer to disinfect her hands as she was leaving the room. Staff F, failed to wash hands prior to exiting the room. An observation on 2/5/19 at 10:45 AM, revealed Staff G, Registered Nurse (RN) walked into the resident's room with a breakfast tray, with ungloved hands moved tray table and items on tray table around, set the tray on the tray table, set the tray up for the resident to eat, then left the room. Staff G, RN failed to wash hands and failed to put on or take off gloves or gown when entering or exiting the room. An interview on 2/5/19 at 10:58 AM, Staff G, RN reported staff should glove when entering this resident's room unless they are going to come into contact with bodily fluids then they should gown as well. An interview on 2/6/19 at 3:00 PM, The Director Of Nursing (DON), acknowledged her expectation for staff to be when entering and exiting a C diff contact isolation room staff should always place a gown on when visiting and to place gloves on if you are going to touch anything, both should be removed prior to leaving the room.. Furthermore, hand sanitizer should be used before entering and leaving the room. The DON stated staff	F 880		

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F 880	Continued From page 15 should wash hands when heavily soiled items are touched.	F 880		