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	165155	A. BUILDING _____ B. WING _____	02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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	F 000		
JS	Correction Date: March 16, 2022 A recertification health survey and investigation of Facility Reported Incidents #102254-I and #102701-I was completed 2/16-17/22 and 2/21-24/22 and resulted in the following deficiencies. Facility Reported Incidents: #102254-I was Substantiated #102701-I was Substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/02/2022

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 578	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to document in the clinical record, Advance Directives (written instructions for the provision of health care if the individual becomes incapacitated), including the physicians orders for life-sustaining treatment (POLST), for 1 of 21 residents reviewed (Resident 103). The facility reported a census of 53 residents. 1. The Minimum Data Set (MDS), dated 02/16/22, assessed Resident #103 with a Brief Interview for Mental Status (BIMS) score of 15 (no cognitive impairment). The MDS revealed the resident required extensive assistance of 2 staff with bed mobility, transfers, dressing, toileting, dressing,	F 578		

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F 578	Continued From page 2	F 578		

personal hygiene and bathing. The MDS identified the resident as non-ambulatory (does not walk) and required 1 staff assistance with locomotion per wheelchair. The MDS listed diagnoses that included: disorders of the cranial nerves (injury to the cranial nerves affecting sensation and /or movement), deep venous thrombosis (blood clot to a deep vein), heart failure, peripheral vascular disease (PVD) (reduced blood flow, typically in the legs), diabetes mellitus, cerebral vascular accident(CVA)(blood vessel injury in the brain), depression with an adjustment disorder(emotional or behavioral reaction to a stressful event or change in a person's life) and Meniere's disease (inner ear disorder causing dizziness).

On 02/17/22 at 10:29 AM, the electronic medical record (EMR) did not contain physician orders addressing advanced directives for code status (type of emergent treatment if experienced cardiac or respiratory arrest). A review of the facilities paper binder of IPOSTs (Iowa Physician Orders for Scope of Treatment), revealed no documentation for the resident's directives.

On 02/21/22 at 10:31 AM, the DON confirmed lack of clinical documentation or physicians orders for the resident's wishes on advanced directives and emergent treatment. The DON stated she would investigate with the admitting nurse manager.

On 02/22/22 at 07:43 AM, the DON identified the IPOST information as located in the managers office and stated she updated the EMR and faxed the paperwork for the physicians signature, as of the afternoon of 02/21/22. The DON stated she

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F 578	Continued From page 3 expected advanced directives addressed and documented on admission and the IPOST available for reference in the facility designated IPOST binder.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must– (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582		

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F 582	Continued From page 4 facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide 2 of 3 residents (Residents #21 & #49) the required Medicare Liability Notices and Beneficiary Appeals form when skilled services exhausted or services no longer covered. The facility reported a census of 53 residents. Findings Include: 1. Record review for Resident #21 indicated the resident received skilled services from 9/30/21 through 11/12/21, and the resident remained in the facility following the skilled services. The facility failed to provide the resident &/or the resident representative the 48 hour notice with the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN), Center of	F 582		

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F 582	Continued From page 5 Medicare Services (CMS) form #10055. The facility provided the resident the Notice of Medicare Provider Non-coverage, CMS form #10123. 2. Record review for Resident #49 indicated the resident received skilled services from 8/18/21 through 9/30/21, and the resident remained in the facility following the skilled services. The facility failed to provide the resident &/or the resident representative the 48 hour notice with the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN), Center of Medicare Services (CMS) form #10055. The facility provided the resident representative the Notice of Medicare Provider Non-coverage, CMS form #10123. On 2/22/22 at 10:23 AM, the Social Services Designee (SSD) identified starting training in the Social Service position in July/August 2021 with the previous SSD who trained her on CMS forms #10055 and #10123, however, missed completing them for Resident #21 & #49. The SSD confirmed Resident #21 on skilled care 9/30 - 11/12/21 and Resident #49 on skilled care 8/18 - 9/30/21; both residents remained in the facility following the skilled care. The SSD stated unaware form #10055 required completion when a resident stayed in the facility following skilled care. The SSD started completing form #10055 after February 1, 2022, when a resident stayed in the facility following skilled care.	F 582		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		

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F 641	Continued From page 6 resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to document accurate assessment on the Minimum Data Set tool used by nursing home to assess and plan care for residents for 1 of 19 residents reviewed. (Resident #47)The facility reported a census of 53 residents. Findings include: A Minimum Data Set (MDS) dated 10/5/21 MDS assessed Resident #47 with a Brief Interview for Mental Status (BIMS) score of 10 (moderate cognitive impairment). The resident required extensive assistance of one staff for bed mobility and toileting and limited staff assistance with transfers and locomotion. The care plan for Resident #47, updated on 4/27/21, identified the resident with self-care performance deficit related to diabetic neuropathy and identified the resident required Stand by assist with a gait belt and walker. Observation showed on 02/17/22 at 10:52 AM Staff B Certified Nursing Assistant (CNA) assist Resident #47 to bathroom. The resident had an artificial left leg attached at the knee. The CNA used a gait belt to assist with transfer and ambulation. After a fall, the resident had a change in condition MDS dated 11/8/21 that identified the resident as totally independent with transfers and locomotion. The quarterly MDS dated 11/16/21 indicated he required limited assistance of one staff for	F 641		

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F 641	Continued From page 7 transfers. On 02/21/22 at 01:00 PM, the MDS coordinator said she didn't know about his change in status from one assist before the fall, then after the fall no assistance and totally independent and then a week later limited assist of one. She didn't remember and said that it would be in his care plan. The care plan related to transfers was last updated on 4/27/21 and indicated that at that time the resident was independent with transfers in his room. On 2/21/22 at 01:04 PM, the Director of Nursing (DON) thought that the 0/0 for transfers was probably a miss code because the resident had always been at least a stand by assist.	F 641		
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	F 644		

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F 644	Continued From page 8 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 interview, the facility failed to ensure a resident's complete and updated serious mental illness (SMI) diagnoses were submitted for review with PASARR (Preadmission Screening and Resident Review), ensuring a resident with SMI received the proper placement and services they need for 1 of 1 residents reviewed (Resident 45). The facility reported a census of 53 residents. 1. The Minimum Data Set (MDS) for Resident #45, dated 02/01/22, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15 (no cognitive impairment). The resident required 1 person physical assistance with bed mobility, transfers, dressing, personal hygiene and bathing. The resident required extensive assistance of 1 person with toileting. The MDS documented the resident required supervision with eating and locomotion, with the aid of a walker. The MDS listed diagnoses including the resident's primary diagnoses as an adjustment disorder with anxiety (an emotional or behavioral reaction to a stressful event or change in a person's life), diabetes mellitus, non-Alzheimer's dementia, seizure disorder, anxiety disorder, depression, bi-polar disorder (depressive lows to manic highs), mixed obsessive thoughts, extrapyramidal and movement disorder (side effects of antipsychotic medications) and obsessive-compulsive disorder (OCD) (excessive thoughts and repetitive behaviors) . The care plan, dated 01/28/22, identified the	F 644		

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F 644	Continued From page 9	F 644		

resident with impaired cognitive function and impaired thought processes with behavioral disturbance, major depressive disorder, bipolar disorder, OCD with difficulty in decision making and memory loss. Goals listed included having the resident free of signs or symptoms of distress, depression, anxiety or a sad mood. To minimize behaviors related to identified triggers, the care plan directed staff to approach and speak in a calm manner, divert attention and provide for a safe location to calm, as needed. The care plan identified, due to the resident's OCD, a potential nutritional problem exists and to provide for a calm, quiet setting at meals with adequate eating time.

The physician's medication orders included Risperidone (antipsychotic) , Clonazepam (antianxiety) and Sertraline (antidepressant used with OCD).

The clinical record review revealed the most recent PASARR, dated 02/01/18 submitted by Buena Vista Regional Medical Center, listed bipolar disorder as the resident's only SMI. It listed medications of Risperdal (antipsychotic) for bipolar disorder, Zoloft (antidepressant) for dementia/neurocognitive disorder and Zyprexa (antipsychotic).

On 02/22/22 at 09:27 AM, the Director of Nursing (DON), stated the facility unable to locate any additional updated PASARRs in the clinical record. The DON stated she expected a PASARR update and submitted for review when a resident receives diagnoses of additional SMIs. The DON acknowledged they have been challenged with capturing this information timely and submitting an updated PASARR in the past.

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to update care plans to include resident specific concerns for 1 of 19 residents reviewed. Resident #28 had edema and diabetic ulcers and the care plan lacked information or related interventions.. The facility reported a census of 53 residents.	F 657		

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F 657	Continued From page 11 Findings include: A Minimum Data Set (MDS) dated 1/11/22 assessed Resident #28 with a Brief Interview for Mental Status (BIMS) score of 1 (severe cognitive impairment). The resident required limited assistance of one staff for bed mobility, transferring, dressing and toileting needs. The resident had diagnosis of renal insufficiency, diabetes mellitus, and Alzheimer's disease. The resident did not have venous ulcers at the time of admission. The resident admitted to the facility 10/21/21. An admission assessment dated 10/21/21 at 2:59 PM revealed Resident #28 did not have edema in the extremities at the time of admission. The care plan updated on 1/11/22 revealed nutritional problems related to morbid obesity and severe protein malnutrition. The care plan included a goal for the resident to maintain a stable weight and instructed staff to monitor weight. The care plan revealed the resident had renal insufficiency related to chronic kidney disease with a goal to prevent complications related to fluid overload. The care plan directed staff to monitor for dependent edema. Observation showed on 2/21/22 at 3:09 PM the physical therapist (PT) and Registered Nurse (RN) provide wound care in the therapy room. Observation showed extensive skin pealing and many reddened and open areas on bilateral lower extremities (BLE). The posterior left calf contained a black and necrotic area. A faxed document dated 12/8/21 sent from the facility to the physician contained information that	F 657		

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F 657	Continued From page 12 the resident had 4+ pitting edema to the BLE and fluid blisters. The follow up to the fax was a physician order to start diuretic therapy; Lasix 20 milligrams daily and to wrap legs with ace bandages. A report dated 1/25/22 from the wound care physician identified 5 areas with skin ulcerations: 1) Site 1, left shin measured 4 centimeter (cm.) by 4.6 cm. by 0.3 cm with a surface area of 18.40 cm. 2) Site 2, right shin resolved on 1/25/22. 3) Site 3, right upper medial thigh measured 6.5 cm. by 1 cm. by 0.3 cm. with a surface area of 6.50 cm. 4) Site 4 posterior lower calf measured 3 cm. by 4 cm. by 0.2 cm. with a surface area of 12 cm. 5) Site 5 right anterior ankle measured 1 cm. by 1.4 cm. by 0.1 cm. with a surface area of 1.40. The orders tab in the electronic chart revealed the addition of antibiotics and stronger pain medications on 2/16/22 at 2:00 PM. The care plan lacked any reference to the increased edema and diabetic ulcers. On 2/24/22 at 9:30 AM the Director of Nursing (DON) stated the care plan should contain information and interventions for these areas of concern.	F 657		
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	F 684		

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F 684	Continued From page 13 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, record review and staff interview, the facility failed to conduct neurological assessments after an unwitnessed fall and failed to ensure new interventions following the fall were implemented for one of 4 residents reviewed. (Resident #22) Facility census was 53 residents. Findings include: The Minimum Data Set (MDS) dated 12/21/21, assessed Resident #22 with a Brief Interview for Mental Status (BIMS) score of 9 (moderate cognitive impairment). Resident #22 required extensive assistance of 1 staff with bed mobility, dressing and toileting. The resident required limited assistance of 1 staff with transfers, walking in room or corridor, personal hygiene and bathing. The MDS identified the resident as unsteady and only able to stabilize with staff assistance. The resident used a walker or wheelchair for locomotion and 1 person physical assistance. The MDS listed diagnoses including Parkinson's disease (disorder of the central nervous system affecting movement and includes tremors), coronary artery disease (CAD), heart failure, non-Alzheimer's dementia and unspecified abnormalities of gait and mobility. The care plan, dated 12/02/21, identified a focus area of limited mobility related to Parkinson's disease evidenced by shuffling gait and the need for assistance with mobility and described the	F 684		

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resident as at risk for falls. The care plan identified the resident as requiring 1 staff assistance with transfers and ambulation with interventions that included: use of a Dycem (anti-slip material to prevent sliding from a seated position) in his recliner.

A review of facility policy titled Sanford Policy Rehab/Skilled Nursing Fall Prevention and Management dated 09/17/2021, identified the goal as promoting resident well-being, identify risk factors and implement interventions before a fall occurs to prevent further injury. The policy directs if a fall is not witnessed, neurological checks are required and recommended to document in the medical record using the Neuro Check assessment tool in the electronic medical record (EMR).

The Neuro Check EMR (electronic medical record) template directed to record observations following a fall resulting in known or possible head injury or any other conditions requiring neuro-checks, e.g. TIA (transient ischemic attack/stroke), Bells Palsy. The document directed staff to use the form when conditions indicate and to continue neuro-checks every 30 minutes times 4, then every 8 hours for 3 days, or as directed by the provider.

The clinical record revealed the resident had an unwitnessed fall on 01/19/22 at 14:43 PM. Documentation described the resident as found on the floor in front of his recliner, with no apparent injury. No staff were identified as a witness at the time of the fall. The resident stated he slid from the chair onto the floor. Initial assessments were documented, per facility policy. The Interdisciplinary team (IDT) met and

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F 684	Continued From page 15 the use of the Dycem in his recliner was implemented and added to his care plan, dated 01/19/22. The clinical record revealed to further documentation of assessments or neuro checks, related to the residents fall, until 01/21/22 at 19:12 PM, a period of approximately 52 hours. On 02/22/22 at 08:02 AM, in a joint observation of the resident's room with the DON, revealed no Dycem anti-slip material was located on his chair(s) or in his room. The DON stated sometimes the material goes to the laundry and doesn't get replaced. The DON stated she expects the material to be in place and utilized, as directed by the care plan. On 02/22/22 at 09:10 AM, in an interview and joint record review with the DON, acknowledged the clinical record lacked documentation of assessments or neuro checks from the initial assessments documented at the time of the fall until the next entry on 01/21/22 at 19:12 PM. Acknowledged, as staff was not present to witness the fall, it should be considered as unwitnessed and facility policy of neuro checks every 30 minutes times 4, then every 8 hours times 3 days should have occurred. Stated her expectation is to perform assessments and neuro checks, per the facility fall policy.	F 684		
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	F 689		

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F 689	Continued From page 16 §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 observations, record review and staff interviews, the facility failed to prevent accidents and hazards for 1 of 4 residents reviewed. Resident #47 fell in a parking lot of a local gas station when staff failed to ambulate the resident with a gait belt as the resident walked on uneven ground. The resident transported to the hospital and admitted to ICU (intensive care unit) after scans showed a subdural hematoma from the fall. The facility reported a census of 53 residents. Findings include: 1. A Minimum Data Set (MDS) dated 10/5/21 assessed Resident #47 with a Brief Interview for Mental Status (BIMS) score of 10 (moderate cognitive impairment). The resident required extensive assistance of one staff for bed mobility and toileting. Transfers and locomotion required the limited assistance of one staff. The care plan updated on 4/27/21, identified Resident #47 with a self-care performance deficit related to diabetic neuropathy. The care plan revealed the resident at risk for falls and alteration in activity related to loss of lower limb and he was learning to balance and walk with prosthetic leg. The care plan directed staff to provide stand by assist with a gait belt and walker and to ensure a safe environment. An incident report dated 10/28/21 at 2:18 PM revealed Staff F Licensed Practicing Nurse was	F 689		

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summoned to a local gas station. The facility van driver stopped at a local gas station and allowed the resident to get out. The resident fell in the parking lot. Staff F stated when she arrived at the gas station, she observed the resident laying on the concrete ground approximately 5 feet away from the vehicle and the back of his head was bleeding. Emergency medical technicians (EMTs) arrived and transferred the resident to the hospital.

An emergency department note dated 10/28/21 identified the chief complaint as "fall". The resident walked outside and tripped, The resident fell backwards and hit the left posterior aspect of his head and also his left elbow. The resident reported 6 out of 10 head pain on a scale of 0-10 with 0 being no pain and 10 being the worst imaginable pain. The report identified a left elbow abrasion. A computerized tomography (CT) scan of the head performed 10/28/21 identified a very small acute subdural hemorrhage adjacent to the falx with maximum thickness measuring 3 mm (millimeter). No midline shift or mass effect. The CT report also identified a left parietal scalp soft tissue hematoma. X-rays of the chest, pelvis and left elbow did not identify fractures. The ED report revealed the resident admitted to ICU (intensive care unit) in guarded condition.

A discharge summary dated 11/2/21 identified admitting diagnosis as: fall. The principal diagnosis (definitive condition responsible for admission) listed as subdural hemorrhage.

On 2/21/22 at 12:05 PM Staff A Certified Nursing Assistant) stated she drove the van. She identified herself as very familiar with the residents and their transfer and ambulation

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needs. She stated in October when Resident #47 fell at the gas station, they were on their way back to the facility after an appointment and the resident asked her to stop at the convenience store so he could buy something. She stated she drove the facility van that did not have a wheel chair lift and the resident sat in the front seat. Staff A stated the resident required assistance with transferring in and out of the van, and with his prosthetic leg, he required guidance and help. Staff A said the resident transferred out of the van without problems and she stayed next to him, without using a gait belt, as he pushed the walker through the parking lot of the gas station. She revealed the concrete in the parking lot very uneven with areas of cracks and heaving slabs. There were many areas where there were lips in the concrete and the resident used a walker with wheels on the front legs and skies in the back. Staff A said that the resident did not rush with his ambulation, but moved forward very slowly because of the prosthetic leg. She stated as she walked along side of him, the front wheels of the walker got stuck on an uneven area in the concrete. The resident then lost his balance and fell back onto the concrete and hit his head. She thought the walker landed on top of the resident. Staff A reported several bystanders came to assist with keeping the resident warm and support his head while they waited for the ambulance. Staff A remembered that there was no snow or ice on the ground, but the weather was cold. Staff A stated she did not stop at the gas station with any other resident. She sometimes stopped at a drive-through and get something to eat. She said the administration went through policy with her after the incident and she understood what the expectations were going forward.

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F 689	Continued From page 19 On 02/23/22 at 10:06 AM, Staff A stated the resident did not use a gait belt when the fall occurred. She acknowledged there was a gait belt in the van but she did not put it on the resident the day they stopped at the gas station. On 02/22/22 at 11:26 AM the Director of Nursing (DON) stated staff sometimes take residents to the grocery store or other outside activities, however, those residents must be independent and Resident #47 was not. The DON suggested Staff A should have left the resident in the van and gone in to get the food for him. She stated the facility did not have a specific policy related to a resident being independent in order to take them out. The DON said she believed when the residents' walker caught on the concrete, that he over-corrected and then lost his balance and fell backwards. A policy dated 7/19/21 Fall Prevention and Management directed staff to communicate risks and interventions for residents communicate any changes in the resident on daily basis to help prevent falls. A policy titled Vehicle Transfer dated 6/2/21 directed staff to park the vehicle in a flat area with smooth surface and place the gait belt on the resident before transferring unless otherwise contraindicated.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695		

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care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to provide emergency tracheostomy/laryngectomy supplies at the bedside for 1 of 1 residents reviewed (Resident 18). The facility reported a census of 53 residents.

1. The Minimum Data Set (MDS) assessed Resident #18 with a Brief Interview for Mental Status (BIMS) score of 10 (moderate cognitive impairment). The resident required limited assistance of 1 person in bed mobility, walking in his room or corridor, dressing, toileting, personal hygiene and bathing. The MDS listed diagnoses including cancer (malignant neoplasm of the larynx), coronary artery disease (CAD) , Alzheimer's disease, depression and respiratory failure.

The resident's history of cancer required a surgical removal of his larynx with the creation of a stoma (an opening in the neck allowing for breathing). The oropharyngeal (mouth, throat and nasal passages) are no longer connected to his breathing/lungs.

Facility policy titled Sanford Policy Enterprise Rehab/Skilled Nursing for Tracheostomy, Suctioning, Dressing Change and Reinsertion of Tube, dated 10/20/21, identified the purpose of the policy is to provide appropriate care for a resident with a tracheostomy . The policy

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instructs that a handheld resuscitation bag along with oxygen should be considered critical emergency equipment and kept at the bedside. The policy directs that oxygen at 8-10 liters needs to be available in an emergency.

On 02/17/22 at 01:41 PM, Staff E stated she is unaware of an emergency tracheostomy kit for the resident, and thought it may be in the crash cart (cart stocked with emergency medical equipment) located in the nurses station. Stated the resident does not need a kit as he suctions well.

On 02/21/22 at 01:42 PM, in a joint review of the facility policy for tracheostomy and joint observation of the resident's room with the Director of Nursing (DON), revealed the absence of a resuscitation bag. The DON stated the oxygen equipment in the room with attached humidification, allowed for oxygen to be administered up to 3 liters and not capable of delivering oxygen at the 8-10 liters in an emergency, per policy. The crash cart in the nurses station contained a portable oxygen tank and resuscitation bag that could be connected to the resident's laryngectomy cannula. The DON stated the resuscitation bag had been removed from the resident's belongings and placed on the crash cart, following a room transfer in the past and the equipment had been left behind. The DON acknowledged the critical equipment outlined in the facility policy was not at the resident's bedside. The DON stated she would inquire with her national resources to determine the facility policy specific to the resident's laryngectomy.

On 02/21/22 at 03:30 PM, the DON stated she

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F 695	Continued From page 22 consulted with her resources and was instructed the tracheostomy policy is to also cover the care and treatment for a laryngectomy. The DON stated she expected the facility to be in compliance with their policy.	F 695		
F 880 SS=E	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: §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;	F 880		

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F 880	Continued From page 23 (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. §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, record review and staff interviews the facility failed to provide adequate infection prevention and control standards in all areas. Upon entrance, the facility staff were not	F 880		

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wearing eye protection while providing resident cares and the county was in a period of high transmission. In three observations, staff failed to use adequate hand hygiene or proper use of Personal Protective Equipment (PPE). The facility reported a census of 53 residents.

Findings include:

1. Observation showed on 2/16/22 at 11:27 AM all nursing and office staff at the facility wore paper surgical masks and no eye protection.

According to the Centers for Disease Control (CDC) in the areas of substantial high transmission health care professional are to be using eye protection for all patient encounters.

Retrieved on 2/23/22 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html

2. A Minimum Data Set (MDS) dated 2/7/22 assessed Resident #104 with a Brief Interview for Mental Status (BIMS) score of 14 (no cognitive impairment). The resident required limited assistance of one staff for bed mobility, transferring and walking. The resident had diagnoses that included: benign prostatic hyperplasia, dementia, chronic obstructive pulmonary disease.

A nursing note dated 2/11/22 at 8:40 AM revealed the resident tested positive for Covid-19 on that date and the resident entered in isolation droplet precautions in his room.

On 02/17/22 at 08:00 AM observation showed Staff D Registered Nurse (RN) in Resident #104's

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room obtaining his blood pressure and other vital signs. Staff D wore a gown, face shield and gloves. Staff D came out of the residents room and wiped the vitals equipment with Clorox (bleach) wipes. She then laid her face shield on top of the cleaned equipment, removed the gown and gloves and then pulled open the drawers of a cabinet with PPE supplies without sanitizing her hands. She then went into the resident room across the hall, pulled back a curtain in the bathroom doorway and washed her hands in that bathroom. Staff D left Resident #104's room door open.

On 2/17/22 at 9:09 AM Staff B Certified Nurse Aide (CNA) entered Resident #104's room wearing gown, gloves face shield and N95 mask. When Staff B exited the room, she placed the face shield in a drawer without sanitizing it.

On 02/17/22 at 10:22 AM Staff C Certified Medication Aide (CMA) entered Resident #104's room wearing a gown, face shield, gloves and two surgical masks. At 10:29 AM she exited the room, took the gloves off, then gown, and placed the face shield on the handrail. With ungloved hands, she then pushed the gown down into a small trash can containing used gowns.. She then touched all the drawers holding PPE as she looked for something. She then asked another staff member to get her some hand sanitizer. On 2/17/22 at 10:31 AM the other staff member gave her sanitizer and she used it on her hands. She then picked up the face shield still hanging on the handrail and walked down the hallway with it in her hands. The Administrator then reminded her that anything that came out of that room is considered contaminated and should be thrown away. He also reminded her to keep the hand

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sanitizer in her pocket.

3. A MDS dated 1/11/22 assessed Resident #28 with a BIMS score of 1 (severe cognitive impairment). The resident required limited assistance of one staff for bed mobility, transferring dressing and toileting needs. The resident had diagnoses that included: renal insufficiency, diabetes mellitus, Alzheimer's disease. Total number of venous ulcers was zero.

An order tab in the electronic health record (EHR) dated 2/4/22 at 7:00 AM staff revealed orders to apply anasept hydrofera foam to the open areas, apply kerlix and ace wraps three times a week.

On 2/21/22 at 3:09 Staff D RN provided a wound dressing change for Resident #28. The resident had many open areas on the bilateral lower legs. The resident rested her feet on a pad on the floor. Staff D applied lotion to the resident's legs and cut foam pieces to cover the open areas. At 3:12 PM one foam piece fell onto the padding under the resident's feet. Staff D picked the foam piece up and placed it back on the wound. At 3:13 PM another foam piece fell to the floor and Staff D used it on the wound for wound care. The foam pieces fell on the floor two more times and Staff D used them on the open wounds.

On 2/24/22 at 9:38 AM the Director of Nursing (DON) stated she expected staff to sanitize face shields after use in a resident isolation room or throw them away. She stated she expected staff to be familiar with the doffing of PPE as directed by the CDC. She said they should never carry the PPE through the facility.

ON 2/24/22 at 9:38 AM, the DON stated when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 880	Continued From page 27	F 880		

she provided wound dressing changes for Resident #28, she tried to have another person with her with clean hands to hold the foam pieces. She would expect Staff D to cut new pieces after they fell on the floor.

4. A MDS for Resident #2 dated 02/08/22 assessed a BIMS score of 15 (no cognitive impairment). The resident required extensive assistance of 2 staff with bed mobility, transfers, dressing, toileting, personal hygiene and bathing. The MDS identified the resident with impairment of both lower extremities and was only able to stabilize with staff assistance. The resident did not walk and used a wheelchair for locomotion. The resident had diagnoses that included: paraplegia (paralysis of the lower extremities and pelvic organs), anemia (insufficient red blood cells), neurogenic bladder (lacks bladder control) and depression. The resident had a stage 4 pressure ulcer (tissue injury extending into muscle and bone) and moisture associated skin damage.

The care plan, dated 02/03/22, identified a focus area of pressure ulcer development, with a goal of maintaining intact skin. Interventions included daily skin assessments with focus on areas with lack of sensation and exposure to moisture and pressure.

Resident #2 had a physician wound specialist directing treatments which included daily wound cares and dressing changes. The orders, updated 01/05/22, directed nurses to apply calcium alginate rope (helps create and maintain a moist wound environment) to the stage 4 coccyx wound and cover with a foam border dressing daily. The physician further directed that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 880	Continued From page 28 the macerated buttocks wounds were to have calcium alginate and cover with a foam border dressing daily. Nurses were instructed to apply an antifungal barrier ointment to the wounds and keep covered with a foam border dressing. On 02/22/22 at 10:50 AM, observation showed Staff E licensed practical nurse (LPN) perform wound care. Staff E cleansed the wound area with wound wash solution and blotted the area dry with a towel. Staff E then picked up the dressing package containing the calcium alginate and obtained a piece of the calcium alginate from the pack with the same gloved hands. Staff E recognized she did not change gloves and set the calcium alginate down on top of the dressing package. Staff E then removed her gloves, and without any hand sanitization, applied a new set of gloves from her pockets and proceeded to place the calcium alginate on the wound bed. Staff E cut the dressing to length and noted she did not place scissors on the dressing supply barrier surface area. Staff E then opened the side table drawer to look for scissors and finding none, reached into her uniform pocket and produced a pair of scissors. Staff E, without glove change, cut the dressing to length and packed the stage 4 wound with applicator swabs. Staff E then applied a foam dressing to the area. Staff E then removed her gloves, and without hand sanitizing, donned gloves and cut calcium alginate with her scissors and applied the dressing to the buttock wounds. Staff E then applied the barrier cream, without a glove change or hand sanitizing. Staff E then removed her gloves and without hand sanitizing, donned another set of gloves and opened the foam dressing package and applied to the wound area.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 880	Continued From page 29 On 02/23/22 04:35 PM , the Administrator stated he expected staff to follow infection control practices and professional standards when providing wound and dressing care.	F 880		

Tag: F578 Request/Refuse/Discontinue Treatment; Formulate Advance Directives

1. **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   Social services was educated on procedure for obtaining IPOST upon admission agreement and correct way to process in facility to be available to staff members at all times by nurse consultant on 3/3/22.

2. **Address how facility will identify other residents having the potential to be affected by the same deficient practice.**

   All residents have the potential to be affected.

3. **Address what measures will be put into place or what systematic changes made to ensure that the deficient practice will not occur.**

   Social services, nursing and spiritual director educated on IPOST completion procedure. Social services will complete advance care planning progress note and IPOST upon admission, give IPOST to charge nurse, charge nurse will enter into electronic record, SS will make copies for IPOST binder and send for signature. Once signed copy returns to facility, updated copies will be put in binder and IPOST will be scanned into electronic record.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**

   Audits Monitoring IPOST process completion will be completed by social services director or designee weekly x 4, bi-weekly x4 and Monthly x4. Results will be brought to the QAPI committee for further review.

   Completed by: 03/03/2022

Tag: F582 Medicaid/Medicare Coverage/Liability Notice

1. **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   Social services director was immediately educated regarding the need provide ABN to residents ending Medicare stay according to the good Samaritan Policy and procedure SNF MEDICARE PART A ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE on February 22, 2022 by administrator.

2. **Address how facility will identify other residents having the potential to be affected by the same deficient practice.**

   All residents with Medicaid or Medicare benefits have the potential to be affected.

3. **Address what measures will be put into place or what systematic changes made to ensure that the deficient practice will not occur.**

   Social services director was educated on February 22,2022 by the administrator regarding Good Samaritans Society's Policy and Procedure SNF MEDICARE PART A ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**

   Audits Monitoring ABN forms will be completed by Social Services director weekly x 4, Monthly x3. Results will be brought to the QAPI committee for further review.

Completed by: 02/22/2022

Tag: F 641 Accuracy of Assessments

1. **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   MDS coordinator was immediately reeducated regarding the need to review MDS and care plan for accuracy of MDS coding according to the Good Samaritan Policy and procedure "Assessment (MDS)". Education was provided by Director of Nursing on February 21, 2022.

2. **Address how facility will identify other residents having the potential to be affected by the same deficient practice.**

   All residents have the potential to be affected.

3. **Address what measures will be put into place or what systematic changes made to ensure that the deficient practice will not occur.**

   MDS coordinator was reeducated on February 21, 2022 by the Director of Nursing Services regarding Good Samaritans Society's Policy and Procedure "Assessments (MDS)". MDS Coordinator verbalized understanding on February 21, 2022.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**

   Audits Monitoring MDS and careplan accuracy will be completed by MDS coordinator or designee weekly x 4 and Monthly x2. Results will be brought to the QAPI committee for further review.

Completed by: 02/22/2022

Tag: **F 644 Coordination of PASARR and Assessment**

1. **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   Resident # 45 had PASARR submitted for review with updated serious mental illness diagnoses for missing preadmission screening and resident review on March 4, 2022 by [redacted] interim social services designee.

2. **Address how facility will identify other residents having the potential to be affected by the same deficient practice.**

   All residents are at potential for missed PASRR screening.

3. **Address what measures will be put into place or what systematic changes made to ensure that the deficient practice will not occur.**

   Social services reviewed facility policy and procedure "Pre-Admission Screening and Resident Review (PASARR)" on February 22, 2022. Social services also reviewed PASARR regulation on February 25, 2022.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**

   Social services will audit residents diagnosed with possible serious mental disorder, intellectual disability or other related conditions for possible PASRR referral to state designated authority weekly x4 weeks, bi weekly x 2 weeks, monthly x2 months.

   Completed by: 02/25/2022

Tag: F657 Care Plan Timing and Revision

1. **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   Resident #28 Care Plan was reviewed and revised for resident's current care to reflect wounds on February 22, 2022.

2. **Address how facility will identify other residents having the potential to be affected by the same deficient practice.**

   All residents with skin impairment are at risk to be affected.

3. **Address what measures will be put into place or what systematic changes made to ensure that the deficient practice will not occur.**

   The wound nurse was educated on updating care plans with any new skin impairments on February 22, 2022 by the Director of Nursing.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**

   The wound care nurse or designee will be auditing care plans relating to any skin changes updates weekly x4, monthly x4. Results will be brought to the QAPI committee for review monthly.

   Completed by: 02/23/2022

Tag: F 684 Quality of Care

1. **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   All licensed nursing staff educated on neurological assessments and interventions with falls on 03/16/2022.

2. **Address how facility will identify other residents having the potential to be affected by the same deficient practice.**

   All residents are at potential for fall with missed neurological assessment or intervention.

3. **Address what measures will be put into place or what systematic changes made to ensure that the deficient practice will not occur.**

   All nursing staff reviewed facility policy and procedure "Neurological Evaluation" and "fall prevention and management" on March 16, 2022.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**

   Director of Nursing will audit residents who have fallen for appropriate neurological assessments and interventions weekly x4 weeks, bi weekly x 2 weeks, monthly x2 months.

   Completed by: 03/16/2022

Tag: F689 Free of Accident Hazards/Supervision/Devices

1. **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   Resident # 47 was educated that wheelchair is needed to go into stores while with staff members on 11/04/2021. Staff F educated on use of gait belt and policy/expectations for resident transports outside of the facility on 10/28/2021.

2. **Address how facility will identify other residents having the potential to be affected by the same deficient practice.**

   All residents being transported outside of the facility with walker have the potential for risk.

3. **Address what measures will be put into place or what systematic changes made to ensure that the deficient practice will not occur.**

   The administrator and HR educated van drivers on appropriate transfer of residents when transporting outside of the facility on 10/28/2021. Gait belts were added to all facility vehicles on 10/28/2021. Staff were educated on following care plan interventions for safety and reminded of corrective action/one on one education if not on 03/16/2022.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**

   The transport coordinator or designee will audit knowledge of transports weekly x 4, bi weekly x2, monthly x 2 all concerns will be brought to the QAPI meetings.

   Completed by: 02/25/2022

Tag: F 695 Respiratory/Tracheostomy Care and Suctioning

1. **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   Director of nursing placed emergency tracheostomy/laryngectomy supplies at the bedside of resident #18 on 02/21/2022.

2. **Address how facility will identify other residents having the potential to be affected by the same deficient practice.**

   This has the potential to affect all residents with laryngectomy or tracheostomy.

3. **Address what measures will be put into place or what systematic changes made to ensure that the deficient practice will not occur.**

   Director of Nursing Services reviewed facility policy "Tracheostomy, Suctioning Dressing Change and Reinsertion of Tube" on 02/21/2022. Emergency kit equipment will be provided to bedside at time of admission of any resident with tracheostomy or laryngectomy.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**

   Director of Nursing will audit emergency laryngectomy/tracheostomy equipment at bedside of any resident with laryngectomy/tracheostomy audits will be done weekly x 4 then monthly x 2.

   Audit results will be brought to monthly Quality Assurance and Performance Improvement committee for any further review and recommendations.

Completed by: 02/21/2020

Tag: F880 Infection Prevention & Control

1. **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   Administrator reviewed county positivity rates and CMS regulations regarding goggles on February 24, 2022 and educated staff on requirements.

   Staff D, staff C and staff B immediately re-educated on proper donning and doffing of PPE for isolation rooms by infection preventionist on February 17, 2022 upon seeing misuse of PPE.

   Staff D re- educated on proper wound dressing changes, including clean supplies and clean area along with utilizing a team member for help on 02/21/2022 by infection preventionist.

   Staff E re-educated on proper hand hygiene with wound treatments including proper glove changing and hand sanitizing between glove changes by infection preventionist on February 22, 2022.

2. **Address how facility will identify other residents having the potential to be affected by the same deficient practice.**

   This has the potential to affect all residents.

3. **Address what measures will be put into place or what systematic changes made to ensure that the deficient practice will not occur.**

   Infection preventionist provided education on March 16, 2022 to all staff regarding proper donning and doffing of PPE, hang hygiene and wound care using facility policies and checklists provided.

   Administrator provided education on February 24, 2022 to all staff regarding CMS regulations on goggle use.