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	165492	A. BUILDING ____ B. WING ____	C 04/06/2021

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LAKESIDE LUTHERAN HOME	301 NORTH LAWLER STREET EMMETSBURG, IA 50536

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F 000	INITIAL COMMENTS 4/20/21 An investigation of complaint #96521-C was completed on 3/29/21-4/6/21. Complaint #96521-C was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. Total residents: 37	F 000	F 000 This represents our credible allegation of compliance effective April 20, 2021.	
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and chart review the facility failed to provide adequate nursing assessments and intervention to treat residents experiencing constipation, for 4 of 7 residents reviewed, (Residents #1, #5, #6 and #7). The facility failed to monitor the bowel habits and assess for signs and symptoms of severe impaction which caused one resident to suffer from fecal impaction and eventual death, (Resident #1). The facility reported a census of 37 residents. Findings include: 1) A Minimum Data Set (MDS) dated May 3,	F 684	F 684 It is the intent of Lakeside Lutheran Home to ensure that all residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Effective 03/26/2021 the process for monitoring the bowel management (BM) program for Lakeside residents was changed to allow all nursing staff to more readily identify residents who need additional care and services for bowel management, as detailed in the facility BM Protocol, implemented on 03/26/2021. Additionally, daily audits were implemented on 03/26/2021 to identify residents, to include residents #5, #6, and #7, lacking documentation of BMs within the specified timeframe of the facility protocol. These audits will be completed daily for 6 weeks by the MDS Coordinator, or Designee.	

DC

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

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

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F 684	Continued From page 1 2021, showed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive deficit. The MDS showed the resident required extensive assistance with the help of two staff for bed mobility, transferring and toileting. According to the MDS, she had a urinary catheter and was always incontinent of bowel. According to a Nursing Note on 2/24/21 at 12:15 p.m., the resident was admitted to the facility earlier that day with orders for Physical Therapy (PT) and Occupational Therapy (OT) post-surgery after a right hip fracture. The diagnosis tab in the electronic medical chart showed Resident #1 had diagnoses including intertrochanteric fracture of the right femur, essential hypertension and type 2 diabetes. A Care Plan initiated on 2/24/21 included a focus care area of bowel incontinence related to limited physical mobility and staff were directed to provide incontinence cares and to monitor intake and output as per facility policy. A Nursing Noted dated 3/24/21 at 11:37 a.m. described Resident #1 as diaphoretic, unresponsive, cool to the touch with pale skin tone, and the resident was noted to be drooling. Vital signs included: temperature 96.8, pulse 55, respirations 20, blood pressure 68/37, and oxygen level at 88% on room air. The note indicated she had wheezes to bilateral lobes with a cough, and her abdomen was distended with bowel sounds in all four quadrants. The family was notified and emergency transport arranged. According to the Emergency Room Report	F 684	F 684 Continued: After 6 weeks, the daily audits will change to twice a week by the MDS Coordinator or Designee for 4 weeks, then periodically thereafter. A Daily BM Monitoring Form was implemented on 03/26/2021 to ensure nursing staff on all shifts are aware of residents identified as needing the BM protocol implemented, with follow up as needed. An online education regarding the new facility BM protocol was initiated on 04/01/2021, to be completed by all nursing staff. Effective 04/20/2021, all resident care plans were updated to reflect directives to monitor BMs for constipation. Additionally, the facility admission orders for each new admission have been updated to reflect the BM protocol. Any identified concerns relating to the BM protocol will be presented to the QA Committee for feedback and resolution, monthly or on an as needed basis.	

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F 684	Continued From page 2 initiated by a Physician's Assistant (PA) and signed by a Medical Doctor (MD) on 3/27/21 at 9:24 p.m., the resident presented to the emergency room on 3/24/21 at 12:41 p.m. with syncope, hypotension, fecal impaction, pneumonia, dementia and systemic inflammatory response syndrome. A facility Nursing Note dated 3/24/21 indicated the resident passed away in the hospital at 6:00 p.m. on that date. The Death Certificate for Resident #1 showed the immediate cause of death was small bowel obstruction. A review of the facility clinical chart for Resident #1 revealed the following: a) Skilled Nursing Forms completed twice daily included areas of assessment for all-body systems. Specific symptoms were listed in each category and the nurse could check those that applied. From 3/20/21 through the morning of 3/24/21 the category of gastrointestinal included documentation that indicated the bowel sounds were present in all four quadrants and the abdomen was soft with no distention. In the category of the respiratory system, it was documented the resident did not have a cough or shortness of breath. b) The Bowel Movement (BM) documentation form found in the facilities electronic charting showed Resident #1 did not have any bowel movements on March 21, 22, 23 or 24. c) A Nursing Note entered on 3/24/21 at 12:34 p.m. but timed at 7:00 a.m. on 3/24/21, indicated	F 684		

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F 684	Continued From page 3 the residents abdomen was non-distended and soft, bowel sounds were present in all four quadrants, the resident did not have a cough and lungs were clear. d) Physician orders for laxative options include the following: Bisacodyl suppository 10 milligrams (mg) insert 1 suppository rectally every 72 hours as needed to promote bowel movements, dated 2/24/21. Milk of Magnesia Suspension, (MOM) give every 24 hours as needed to promote stool, dated 2/24/21. Polyethylene Glycol as needed for constipation once daily, dated 2/24/21. According to the Medication Administration Record (MAR), the resident did not have any laxatives in the month of March. 2) An MDS dated 2/10/21 showed Resident #5 had a BIMs score of 3 out of 15, indicating severe cognitive deficit. The MDS included diagnoses of repeated falls, chronic pain syndrome, obesity and vascular dementia. The document showed the resident required extensive assistance with the help of two for bed mobility, toilet use and personal hygiene and that he was frequently incontinent of bowel. A Care Plan updated on 8/10/18 included a focus area of self-care performance deficit related to lower body weakness and lacked references to, or directions related bowel functioning. In an observation on 3/30/21 at 8:20 a.m., Licensed Practicing Nurse (LPN) Staff A administered medications to Resident #5. She asked him if he had any pain and went to the	F 684		

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electronic chart to document. After looking through his chart, she then went back into the room and offered him MOM because he hadn't had a bowel movement for two days. He refused at that time.

A review of the clinical chart for Resident #5 revealed the following:

a) The resident had a BM on 3/8/21 and none on 3/9, 3/10, 3/11 or 3/12. Nursing Notes lacked any reference to offering a laxative.
b) The resident had a bowel movement on 3/19/21 and none on 3/20, 3/21, 3/22 or 3/23. Nursing Notes lacked any reference to offer of medication to promote bowel movement in that time frame.
c) A Physician's Order dated 8/3/18 at 3:00 p.m. for Bisacodyl suppository 10 mg insert 1 rectally to promote bowel movement. An order dated 3/30/21 at 10:38 a.m. for MOM to be given every 24 hours as needed to promote stool.

Resident #5's MAR lacked documentation that any laxative or suppository had been administered in the month of March until 3/30/21 at 10:38 a.m..

3) An MDS dated 12/26/20 showed Resident #7 had a BIMS score of 0 out of 15, indicating severe cognitive deficits. The MDS indicated the resident required extensive assistance with the help of two staff for transfers, bed mobility, toileting needs and the resident was always continent of bowel.

The Care Plan last updated 12/20/19 for Resident #7 indicated she had some bowel incontinence related to mental status, and staff were directed

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to provide clothing that was easy to remove for incontinence cares. The Care Plan lacked direction to monitor bowel movements for constipation. The Care Plan included diagnosis of obstructive pulmonary disease, edema, schizophrenia, constipation, and a history of diseases to the digestive system.

A review of the clinical chart revealed the following:

a) A Physicians' Order for two scheduled laxatives was entered 10/11/19 at 7:00 a.m.; Senna 8.6 mg. 2 tablets daily, and polyethylene glycol 17 grams daily. On 1/9/19 at 11:15 a.m. a "as needed" (PRN) order for Bisacodyl suppository 10 mg to promote stool was added. On 2/17/21 at 6:00 p.m. an order for MOM daily as needed for bowel movement was added.
b) The electronic bowel movement record indicated the resident did not have a bowel movement on 3/19, 3/20 or 3/21.
c) The MAR showed that no MOM or suppository was given until 3/24 and the Nursing Notes lacked documentation that PRN laxative were offered.

4) An MDS assessment for Resident #6 showed the resident had a BIMS score of 0, indicating severe cognitive deficits and required extensive assistance with the help of two staff for bed mobility, transfer and toileting. The MDS showed the resident was frequently incontinent of bowel and had diagnoses that included spinal stenosis, utero-vaginal prolapse, fracture of the pelvis, and cognitive communication deficit.

According to the census page in the electronic chart, Resident #6 was admitted to hospice

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service on 10/29/20.

A Care Plan updated on 1/7/21 indicated the resident had self-care performance deficits related to altered mental status and included a focus area of occasional bladder and bowel incontinence related to confusion. The Care Plan lacked interventions related to monitoring of bowel movements.

A review of the electronic chart revealed the following:

a) Physician's Order dated 6/25/21 at 11:00 a.m. for Bisacodyl suppository 10 mg every 72 hours as needed for constipation and an order dated 3/24/21 at 5:30 p.m. for MOM every 24 hours as needed to promote BM.
b) The bowel movement charting showed Resident #6 had no bowel movements on 3/27, 3/28 or 3/29.
c) Nursing Notes lacked documentation that PRN laxatives had been offered on 3/28 or 3/29. The MAR indicated that on 3/30 at 10:08 a.m. a suppository was administered and the bowel documentation showed that she had a BM at 2:24 p.m. that day.

During interview on 3/30/21 at 9:00 a.m. Emergency Medical Technician (EMT), Staff G said she was one of the two EMTs that transported Resident #1 to the emergency room on 3/24/21. She said when she walked into the resident's room, the resident had been sitting on the side of the bed. She said the resident was confused and the staff had reported that the change in condition had just happened. Staff G recalled the resident abdomen was distended and compared it to the size of a 7-8 month

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pregnancy. Staff G said she helped change the resident's clothing when they got to the hospital and remembered the resident clenched and called out as if in pain when she was transferred.

During interview on 3/30/21 at 9:10 a.m. EMT Staff H recalled having assisted with the transfer to the hospital for Resident #1. He thought there were 3 or more staff in the room with the resident when they arrived and the resident was lethargic but awake. He remembered the very low blood pressures and when they moved the resident from the bed to the cot he had noticed the distension of the belly and described it as firm.

During interview on 3/30/21 at 9:45 a.m. Licensed Practicing Nurse (LPN) Staff A said that before breakfast she did the skilled assessment for Resident #1 and described the resident as being alert, talking and eating. She added that her vital signs were all within normal limits. Staff A said the resident had participated in therapy that morning and she had visitors but then, close to lunch time, one of the aides came and told her that the resident was diaphoretic and unresponsive. Staff A said she then did another assessment and found the blood pressure to be very low, the abdomen was distended and firm, bowel sounds hypoactive and her oxygen level was very low. Staff A said she had worked with the resident the day before and there was nothing out of the ordinary on that day. She went on to say that after Resident #1 went to the hospital, the facility established a new protocol for bowel movement monitoring with the overnight nurse documenting on a form which residents have not had BM for 2 days and give this to the day shifts. She said they were to offer MOM after 2 days of no BM and a suppository after 3 days of no BM.

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F 684	Continued From page 8 During interview on 3/30/21 at 10:00 a.m. Certified Med Aide (CMA) Staff B said Resident #1 had been friendly, laughing and joked with them the morning of 3/24/21. She hadn't seen anything unusual that morning or previous days leading up to the hospitalization. She said Resident #1 had some leg pain and would grimace once in a while when they transferred her, but Staff B maintained that she never saw or heard her complain of pain in her belly. Staff B said that she hadn't notices an increase in the size or firmness of the resident's abdomen. Staff B said she documented the BM's and reported to the nurse if a resident had gone for 2 or more days without BM. She said if a resident had loose stools after days of no BM she would report this also, knowing that this is a sign of impaction. During interview on 3/30/21 at 10:15 a.m. Physical Therapist, Staff C and Occupational Therapist, Staff D recalled having worked with Resident #1 the morning that she went out to the hospital. They said that they both had worked with her for about 15 minutes each and Staff C said that they had worked on sit to stand exercises. Staff D worked on some exercises with resident while she was sitting in her wheel chair. Staff C and Staff D denied having seen anything out of the ordinary for her. They said that the resident had a bit of an abdominal pouch upon admission, but they did not notice that this had gotten larger, more firm or that the resident complained of abdominal pain. Staff C said the resident was able to make her needs known, she would say if it was difficult for her to do the therapies. During interview on 3/30/21 at 10:20 a.m.,	F 684		

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F 684	Continued From page 9 Certified Nursing Assistant (CNA) Staff E stated she had gone into the room of Resident #1 the morning of 3/24/21, cleaned her up and had gotten her dressed. She said she did not remember any grimacing or anything different about the resident. She said that she hadn't noticed anything different about the resident's abdomen. Staff E remembered Resident #1 had visitors that morning and that therapy had worked with her. Staff E said the resident had been in her wheel chair at the nurse's station waiting for lunch when another aide motioned to her to assist because the resident went limp. She said that they took the resident to her room and put her on the bed, and the resident was cold to the touch and not very alert. She said the nurses took vitals and called the ambulance. Staff E said she always documented the resident's BM's and reported to the nurse if a resident had gone for a couple of days without a BM. In an interview on 3/30/21 at 10:40 a.m., CNA Staff F said she typically worked afternoons on the weekends. She said she hadn't noticed anything different about Resident #1 leading up to the hospitalization. She said that she would turn the resident a couple of times through the night and had done brief changes but said it was normal BM, nothing out of the ordinary. Staff F said she would report any runny stools or abnormal BM patterns to the nurses. During interview on 3/30/21 at 9:00 a.m. the Physician's Assistant (PA) said she had been working in the Emergency Department (ED) the day Resident #1 came to the hospital. She said she primarily worked in the emergency department but had seen the resident in the clinic previously, so she was familiar with her. The PA	F 684		

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F 684	Continued From page 10 recalled that when she first saw Resident #1 in the ED her abdomen was extremely firm and distended. She compared it to the size of a 9 month pregnancy. The PA said the resident moaned when she touched the abdomen and the X-Ray had shown that she had impacted fecal matter the size of a football in her intestine. The PA said the resident's husband said he had just visited her in the nursing home that morning and that she had been drooling, which was unusual for her. The PA stated they had offered to take the resident to surgery to remove the impaction but the family opted not to do that. The plan of care was to provide intravenous fluids and with the use of naso-gastric tubing to remove contents of the stomach. The PA said they removed copious amounts of matter from the stomach, and the low blood pressures were very concerning. She added that the buildup of fecal matter had been pushing on the vena cava, causing the decrease in blood flow. She said the resident never did make it to the Med-Surg department and had passed away in the ED. The PA said that in her opinion, the buildup of fecal matter in the resident's digestive systems would have happened over many days or weeks. She believed that the distended, firm abdomen would have been evident in the days leading up to 3/24/21. She said that nursing staff may have seen and increase in weakness, a decrease in intake and pain in the abdomen. During interview on 3/30/21 at 3:55 p.m. the Director of Nursing (DON) said the facility did not have a policy related to PRN laxative use or specific directives to monitor bowel movements. She said the expectation had been that on day two with no BM the nurses were to offer MOM and on day three without a BM, they were to offer	F 684		

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F 684	Continued From page 11 a suppository. During interview on 3/31/21 at 10:00 a.m., the DON said the facility initiated a new performance improvement plan initiated on 3/26/21 related to monitoring of BMs. When asked why this had been started, she said it was because they discovered that one of the residents had not been monitored for BM's per protocol. The performance improvement plan initiated on 3/26/21 indicated the goal is that no resident would go beyond 2 days (of no BM) without intervention. On 3/31/21 at 10:30 a.m., the DON said she was unable to find education of staff on bowel monitoring. She said they were working to get something assigned right away to their electronic education service. During interview on 3/31/21 at 6:45 a.m. LPN Staff K said the expectation is after 2 days of no BM, the nurses are to offer MOM and after day 3 offer a suppository. She said that sometimes the residents may refuse and they also try to offer prune juice as well. During interview on 3/31/21 at 12:50 p.m., LPN Staff L said after 2 days of no bowel movement she would offer MOM or prune juice, if the resident goes 3 days without BM, she would offer a suppository. During interview on 3/31/21 at 1:30 p.m. RN Staff M said he works the overnight shifts. He said that he would often do the skilled assessment at the beginning of his shift from 6pm-6am. Staff M said he had not noticed anything different with	F 684		

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F 684	Continued From page 12 Resident #1 before her hospitalization and that her abdomen had been within normal limits with no distention or firmness. He said if a resident would go for two days without a bowel movement he would offer MOM and a suppository after three days of no bowel movement.	F 684 F880	It is the intent of Lakeside Lutheran Home to maintain an infection control program designed to provide a safe, sanitary environment to prevent the transmission of disease and infection. On April 16, 2021, the Lakeside Director of Nursing provided re-education to Staff L regarding the proper use of PPE, to include gowning and gloving, when providing cares to a resident in quarantine. Additional re-education was also provided to Staff L regarding the facility process for the proper sanitization of vitals equipment in between each use, to prevent the spread of infectious pathogens. The QAPI Nurse, or Designee, will complete random audits 2 times a week for 6 weeks, and randomly thereafter, to ensure continued compliance. Any identified concerns relating to the proper use of PPE, gloves, and the disinfecting of vitals equipment, will be presented to the QA Committee for feedback and resolution, monthly or on an as needed basis.	
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: §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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165492	A. BUILDING ______ B. WING ______	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 13 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. §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 and interview the facility failed to mitigate the spread of pathogens. The nursing staff failed to wear all the required	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 14 Personal Protective Equipment (PPE) required when providing care to a resident that was quarantined. The nursing staff also failed to clean the vitals equipment between uses from one resident to another. The facility reported a census of 37. Findings include: In an observation on 3/30/21 at 8:27 a.m. Licensed Practicing Nurse (LPN) Staff L was in the room of Resident #8 taking his vital signs with the equipment on a portable stand. She listened to his lungs and bowel sounds with a stethoscope which she placed around her neck when she was finished. The nurse was not wearing a protective gown or gloves. A sign was posted outside of the resident's room that indicated gown and gloves were to be worn when entering the room. When Staff L completed her assessment on Resident #8, she pushed the vitals equipment into two other resident's rooms without having wiped it down or disinfecting the equipment. During interview on 4/6/21 at 9:00 a.m. the Director of Nursing (DON) stated she would expect the nurses to use gloves and gowns when getting vitals on a quarantined resident. She also expects that the vitals equipment is wiped with disinfectant wipes between every use. The DON said the facility did not have a policy on precautions to use with a resident that is in quarantine or on disinfecting the vitals equipment between uses.	F 880		