DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0034	A. BUILDING: _____ B. WING _____	08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME APARTMENTS	1413 2ND AVE VINTON, IA 52349

(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) COMPLETE DATE
A 000	Initial Comments Assisted living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 15 Number of tenants with cognitive disorder: 0 TOTAL census of Assisted Living Program: 15 There were no regulatory insufficiencies cited during the onsite infection control survey. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000	POC 12/6/21	
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff completed two hours of mandatory dependent adult abuse training within six months of employment. This pertained to 1 of 1 staff employed greater than six months (Staff A). Findings follow: 1. Record review on 8-11-21 of Staff A's training documents revealed a hire date of 10-22-19. Staff A had a Certificate of Completion document for completing Mandatory Reporter Training In Recognition and Reporting of Child and	A 380	**All employees will complete the dependent adult Abuse training required by Iowa Code section 253B.16. The employee will complete this training with in the first six months of employment. This process Will begin December 1, 2021. All staff who are involved in the hiring processes will be educated about the requirement of Dependent Adult Training and that all staff will be required to complete within six months of hire. The human resources staff at the corporate office will be responsible for asking new employees if they have had this training and if not, the corporate office staff will communicate with Assisted Living managers to ensure the training is completed with in 6 months of employment. Employee files will be audited for one year to ensure that all employees have completed Dependent adult abuse training within 6 months. These audits will monitor compliance and will begin January 1, 2022. The audits will be completed every 60 days. The reports will be shared at QA meetings every 60 days. If audits are not 95% accurate, the audits Will continue for another 6 months.**	

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A 380	Continued From page 1 Dependent Adult Abuse dated 6-11-19. The certificate was from a hospital and was a combined child and dependent adult abuse course (two contact hours). 2. When interviewed on 8-16-21 at 3:11 p.m. the Administrator confirmed Staff A did not have any additional dependent adult abuse training.	A 380		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed for 2 of 3 tenants reviewed (Tenant #1 and #3). Findings follow: 1. Record review on 8-12-21 and 8-16-21 of Tenant #1's file revealed an Admission Assessment (change of condition) dated 3-26-21 indicated there was an area under Tenant #1's right breast. It was measured and a picture sent to the primary care provider (PCP). Staff	A 145	The Administrator will conduct a meeting on December 3, 2021 to educate all registered nurses to Ensure all tenants are evaluated with any Significant changes in condition, but not less than annually to determine the tenant's continued eligibility for the program and determine any changes to services. This assessment will include an evaluation of the tenant's functional, cognitive and health status. The assessments will be given to the Director of Nurses or the Administrator upon completion. Starting December 6, 2021, The Administrator will be responsible for compliance by auditing the assessments and tenant files at least every 60 days. These findings will be documented and shared at QA meetings every 60 days. The audits will continue for one year. If after a year the audits Are not 95% accurate, the audits will continue for another 6 months.	

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A 145	Continued From page 2	A 145		

reported a reddened area/sore under the right breast. The area was 2 x 1.75 inches, red and drained a small amount of yellow/tan drainage. A foul odor was also noted. The PCP was notified and an order was received for a nurse to apply Mepilex dressing to the area area and Desitin ointment to the excoriated areas under the breast. The nurse was to change the dressing three times daily. Staff was informed of the area and to avoid getting it wet during showers. Staff would call the nurse if the dressing came off. The assessment indicated Tenant #1 had breast cancer bilaterally and did not want any treatment.

Continued record review revealed a Home Health Certification and Plan of Care document reflected Tenant #1 received home health agency (HHA) services with a certification period of 4-13-21 to 6-11-21. The document indicated Tenant #1 was recently diagnosed with terminal breast cancer after staff noticed a large mass and wound on her right breast with lymph node involvement. Tenant #1 was not a surgical candidate and decided not to complete treatment. The right breast wound had grown "significantly" larger in the past few weeks and required daily dressing changes that were completed by staff or a skilled nurse (SN). The wound measured 9 centimeter (cm) x 6 cm x 0.2 cm. Tenant #1 had no pain related to the wound.

A Home Health Certification and Plan of Care document reflected Tenant #1 received HHA services from 6-12-21 to 8-10-21 and from 8-11-21 to 10-9-21. The Home Health Certification and Plan of Care document signed on 8-9-21 (8-11-21 to 10-9-21) indicated the wound measured 9 cm x 8 cm and depth was measured at 4 cm; however, might not be accurate due to the slough tissue present. The

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A 145	Continued From page 3	A 145		

wound had a moderate amount of bleeding; however, it stopped after several minutes of gentle pressure. If the bleeding was not able to be stopped, Tenant #1 would need to be seen in the emergency room. Tenant #1 had no pain related to wound.

Further record review revealed a wound clinic document dated 6-3-21 indicated the wound care goals for Tenant #1 were palliative and not curative. The goal was to minimize complications, prevent infections, manage draining, decrease odor and minimize Tenant #1's pain.

Continued record review revealed a PCP Clinic Note dated 7-22-21 indicated Tenant #1's right breast tumor kept eroding and deepening. "She has now a very large cavitating wound with bleeding on the edges and necrosis in the middle. It appears to go clear to the chest wall. Before it got his bad, we had sent her to surgery and oncology to see if anything more should be done with this and no treatments, remedies, or surgery was offered. Wound measurement now is 9 cm x 8 cm and the depth is estimated to be to the chest wall by appearance as it cannot be measured." There was also a new area of skin breakdown.

Further record review revealed physician orders indicated the following:

- A Physician's Order document dated 4-9-21 indicated there was increased drainage/odor was noted from the right breast and a wound clinic nurse was consulted for recommendations. Orders were received to increase dressing changes to once per day and as needed for drainage, could increase to twice daily for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 145	Continued From page 4	A 145		

dressing changes if needed. To cleanse the area with mild soap and warm water, rinse and pat dry. Apply Zeasorb AF powder to the surrounding skin and rub in, could put Desitin over the top of the powder if an additional barrier was needed, then cover the wound with abdominal (ABD) pad or gauze and secure with paper tape.

-On 4-13-21 a verbal order was received for a SN or AL staff to complete the dressing changes to the right breast once daily and as needed for increased drainage. Cleanse the area with mild soap and warm water, rinse and pat dry. Apply Zeasorb AF to the surrounding skin and rub in. Desitin could be applied over the top of the powder if an additional moisture barrier was needed. The wound was to be covered with ABD pad and secured in place with tape. Monitor for signs/symptoms of infection daily and measure the wound weekly.

-On 4-23-21 a verbal order was received to discontinue Zeasorb AF and start Zeasorb powder to the periwound skin once per day.

-On 5-18-21 a verbal order was received to discontinue Zeasorb powder and start Nystatin powder.

-On 6-4-21 it was noted the following wound care would be effective until metronidazole was obtained from the pharmacy: once daily to cleanse the area with mild soap and warm water and to rinse and pat dry. Cut Melgisorb Ag in half and apply to the wound bed, Desitin could be applied to the periwound skin if an additional moisture barrier was needed. Cover the wound and Melgisorb Ag with an ABD pad and secure in place with paper tape. When metronidazole arrived the following orders were effective: once

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LUTHERAN HOME APARTMENTS	1413 2ND AVE VINTON, IA 52349

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A 145	Continued From page 5	A 145		

daily to cleanse area with mild soap and warm water and to rinse and pat dry. Apply metronidazole gel to the wound bed twice daily for 14 days, Desitin could be applied to the periwound if an additional moisture barrier was needed. Cover with an ABD pad and secure in place with paper tape. (Clinical Notes dated 6-4-21 indicated Duoderm was framed around the wound to act as a barrier for the tape. Tenant #1 did not want to continue using them after the current Duoderm fell off, which was applied at the wound clinic on 6-3-21).

-On 7-2-21 a verbal order was received for the SN or AL staff to complete the dressing changes to the right breast once daily and as needed for increased drainage. Cleanse the area with mild soap and warm water, rinse and pat dry. Apply Zeasorb powder to the surrounding skin and rub in. Desitin could be applied to the periwound if an additional moisture barrier was needed. Cover with an ABD pad and secure in place with paper tape. Monitor for signs/symptoms of infection daily and measure the wound weekly.

-On 7-26-21 a verbal order was received for the SN or AL staff to complete the dressing changes to the right breast once daily and as needed for increased drainage. Cleanse the area with mild soap and warm water, rinse and pat dry. Apply Micro-Guard powder to the surrounding skin and rub in. Desitin could be applied to the periwound if an additional moisture barrier was needed. Cover with an ABD pad and secure in place with paper tape. Monitor for signs/symptoms of infection daily and measure the wound weekly.

Continued record review revealed SN Clinical Progress Notes indicated the following measurements related to the wound:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 145	Continued From page 6 -On 4-16-21 the wound measured 9 cm x 6 cm x 0.2 cm. -On 4-20-21 the wound measured 9.5 cm x 6 cm x 0.2 cm. -On 4-23-21 the wound measured 9.5 cm x 6 cm x 0.2 cm. -On 4-30-21 the wound measured 10 cm x 7 cm x 0.2 cm. -On 5-7-21 the wound measured 10 cm x 7 cm x 0.2 cm. -On 5-14-21 the wound measured 7 cm x 7 cm x 0.5 cm. -On 5-21-21 the wound measured 7 cm x 7 cm x 0.5 cm. -On 5-25-21 the wound measured 7 cm x 7 cm x 0.5 cm. -On 6-4-21 the wound measured 7 cm x 7 cm x 0.5 cm. -On 6-18-21 the wound measured 9 cm x 8 cm x 0.5 cm. -On 7-2-21 the wound measured 9 cm x 8 cm (depth unable to accurately measure due to slough). -On 7-9-21 the wound measured 9 cm x 8 cm (depth unable to accurately measure due to slough). -On 7-16-21 the wound measured 9 cm x 8 cm	A 145		

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A 145	Continued From page 7 (depth unable to accurately measure due to slough). -On 7-23-21 the wound measured 9 cm x 8 cm (depth unable to accurately measure due to slough). -On 7-30-21 the wound measured 9 cm x 8 cm (depth unable to accurately measure due to slough). Further record review revealed the most recent Admission Assessment (change of condition) evaluations were completed dated 3-26-21. Evaluations were not completed by a Program nurse as needed, as the wound size increased significantly and the depth of wound was indicated to be to the chest wall, with bleeding noted at times and palliative wound care with the wound clinic. 2. Record review on 8-12-21 and 8-16-21 of Tenant #3's file revealed a Skilled Nurse Visit Note dated 6-15-21 indicated the area between Tenant #3's legs and groin was red, excoriated and sore. The PCP was contacted and a verbal order was received to apply Calmoseptine over the counter (OTC), three times daily to areas until healed and then continue twice daily as a barrier related to incontinence. Continue record review revealed a fax to the PCP dated 6-15-21 indicated Tenant #3 had an excoriated area on her buttocks and groin area. A new order was received for Calmoseptine OTC to the excoriated areas three times per day until healed and then twice daily to prevent skin breakdown.	A 145		

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A 145	Continued From page 8 Further record review revealed a Skilled Nurse Visit Note dated 7-16-21 reflected Tenant #3 had an excoriated area approximatley 3 cm x 4 cm on her buttocks. Calmoseptine was applied two to three times daily with improvement. Continued record review revealed the most recent Admission Assessment (change of condition) evaluations were completed dated 5-21-21. A Skilled Nurse Visit Note was completed on 6-15-21 and 7-16-21; however, functional and cognitive evaluations were not completed when the excoriated area was noted, the PCP was contacted and new orders were received for treatment of the area or with the continuation of the excoriated area. 3. When interviewed on 8-16-21 at 3:11 p.m. the Administrator confirmed the most recent evaluations for the tenants listed above were provided.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by	A 290	On December 3, 2021 the Administrator will conduct a meeting to educate the registered nurses about tenant Documentation. When any tenant's health related care is delegated, the Medical information sheet, orders for the health care Professional, such as treatments, therapy, Medications. The nurses notes will be written by Exception. The administrator will instruct the nurses on Which form to use and what information to include with documentation. Starting December 6, 2021, the administrator will ensure compliance, by completing Audits on all tenant documents that include any changes or new treatments,Therapy, or extra medications for accuracy and Completeness for one year. The audit will be completed at least every 60 days will be shared during the QA Meetings every 60 days. If audits are not 95% accurate, the audits will continue for another 6 months.	

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A 290	Continued From page 9 exception. This pertained to 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. Record review on 8-12-21 and 8-16-21 of Tenant #1's file revealed an Admission Assessment (change of condition) dated 3-26-21 indicated there was an area under Tenant #1's right breast. It was measured and a picture was sent to the primary care provider (PCP). Staff reported a reddened area/sore under the right breast. The area was 2 x 1.75 inches, red and drained a small amount of yellow/tan drainage. A foul odor was also noted. The PCP was notified and an order was received for a nurse to apply Mepilex dressing to the area area and Desitin ointment to the excoriated areas under the breast. The nurse was to change the dressing three times daily. Staff was informed of the area and to avoid getting it wet during showers. Staff would call the nurse if the dressing came off. The assessment indicated Tenant #1 had breast cancer bilaterally and did not want any treatment. Continued record review revealed a Home Health Certification and Plan of Care document reflected Tenant #1 received home health agency (HHA) services with a certification period of 4-13-21 to 6-11-21. The document indicated Tenant #1 was recently diagnosed with terminal breast cancer after staff noticed a large mass and wound on her right breast with lymph node involvement. Tenant #1 was not a surgical candidate and decided not to complete treatment. The right breast wound had grown "significantly" larger in the past few weeks and required daily dressing changes that were completed by staff or a skilled nurse (SN). The wound measured 9 centimeter (cm) x 6 cm x 0.2 cm. Tenant #1 had no pain related to the wound.	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 290	Continued From page 10 Further record review revealed a PCP Clinic Note dated 7-22-21 indicated Tenant #1's right breast tumor kept eroding and deepening. "She has now a very large cavitating wound with bleeding on the edges and necrosis in the middle. It appears to go clear to the chest wall. Before it got his bad, we had sent her to surgery and oncology to see if anything more should be done with this and no treatments, remedies, or surgery was offered. Wound measurement now is 9 cm x 8 cm and the depth is estimated to be to the chest wall by appearance as it cannot be measured." There was also a new area of skin breakdown. Continued record review revealed physician orders indicated the following: - A Physician's Order document dated 4-9-21 indicated there was increased drainage/odor was noted from the right breast and a wound clinic nurse was consulted for recommendations. Orders were received to increase dressing changes to once per day and as needed for drainage, could increase to twice daily for dressing changes if needed. To cleanse the area with mild soap and warm water, rinse and pat dry. Apply Zeasorb AF powder to the surrounding skin and rub in, could put Desitin over the top of the powder if an additional barrier was needed, then cover the wound with abdominal (ABD) pad or gauze and secure with paper tape. -On 4-13-21 a verbal order was received for a SN or AL staff to complete the dressing changes to the right breast once daily and as needed for increased drainage. Cleanse the area with mild soap and warm water, rinse and pat dry. Apply Zeasorb AF to the surrounding skin and rub in.	A 290		

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A 290	Continued From page 11 Desitin could be applied over the top of the powder if an additional moisture barrier was needed. The wound was to be covered with ABD pad and secured in place with tape. Monitor for signs/symptoms of infection daily and measure the wound weekly. -On 4-23-21 a verbal order was received to discontinue Zeasorb AF and start Zeasorb powder to the periwound skin once per day. -On 5-18-21 a verbal order was received to discontinue Zeasorb powder and start Nystatin powder. -On 6-4-21 it was noted the following wound care would be effective until metronidazole was obtained from the pharmacy: once daily to cleanse the area with mild soap and warm water and to rinse and pat dry. Cut Melgisorb Ag in half and apply to the wound bed, Desitin could be applied to the periwound skin if an additional moisture barrier was needed. Cover the wound and Melgisorb Ag with an ABD pad and secure in place with paper tape. When metronidazole arrived the following orders were effective: once daily to cleanse area with mild soap and warm water and to rinse and pat dry. Apply metronidazole gel to the wound bed twice daily for 14 days, Desitin could be applied to the periwound if an additional moisture barrier was needed. Cover with an ABD pad and secure in place with paper tape. (Clinical Notes dated 6-4-21 indicated Duoderm was framed around the wound to act as a barrier for the tape. Tenant #1 did not want to continue using them after the current Duoderm fell off, which was applied at the wound clinic on 6-3-21). -On 7-2-21 a verbal order was received for the	A 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 290	Continued From page 12 SN or AL staff to complete the dressing changes to the right breast once daily and as needed for increased drainage. Cleanse the area with mild soap and warm water, rinse and pat dry. Apply Zeasorb powder to the surrounding skin and rub in. Desitin could be applied to the periwound if an additional moisture barrier was needed. Cover with an ABD pad and secure in place with paper tape. Monitor for signs/symptoms of infection daily and measure the wound weekly. -On 7-26-21 a verbal order was received for the SN or AL staff to complete the dressing changes to the right breast once daily and as needed for increased drainage. Cleanse the area with mild soap and warm water, rinse and pat dry. Apply Micro-Guard powder to the surrounding skin and rub in. Desitin could be applied to the periwound if an additional moisture barrier was needed. Cover with an ABD pad and secure in place with paper tape. Monitor for signs/symptoms of infection daily and measure the wound weekly. Further record review revealed SN Clinical Progress Notes (HHA notes) documented weekly measurements of the wound from 4-16-21 to 7-30-21. Continued record review of the Programs nurse's notes (Clinical Notes) reflected two entries in April, one entry indicated new orders were received for wound care. Nurse's notes were not found for May. There were two entries in nurse's notes in June, both entries were related to wound care orders from the wound clinic. There was one entry in nurse's notes in July related to staff training on Tenant #1's dressing change. There were no other nurse's notes completed by the Program (non-HHA notes) related to the wound, treatment or orders.	A 290		

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	S0034	A. BUILDING: _____ B. WING _____	08/16/2021

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A 290	Continued From page 13 2. Record review on 8-12-21 and 8-16-21 revealed an Admission Assessment (change in condition) dated 7-22-21 noted Tenant #2's right lower extremity (RLE) was pink and had an open area. Continued record review revealed a Physician's Orders document dated 7-21-21 reflected an order for Mepilex border, apply to the wound on the right ankle and change every two to three days. To continue anti-embolism hose on in the a.m. and off in the p.m. Further record review revealed a fax to the PCP dated 7-27-21 indicated Tenant #2 had three open areas to the RLE. A verbal order was received including for Mepilex foam, cut to apply to the open (area) on the RLE and wrap with stretch gauze, then apply an ACE wrap to RLE. Dressing changes were to be completed every other day and anti-embolism hose to the RLE was discontinued. A fax to the PCP dated 8-6-21 indicated Tenant #2 requested the dressing change to be completed every Monday, Wednesday and Friday. A verbal order was received to change the dressing to the RLE to Monday, Wednesday and Friday, continue to wrap RLE with stretch gauze, then an ACE wrap with the dressing change. Continued record review revealed the most recent entry in nurse's notes (Clinical Notes) for Tenant #2 was dated 6-3-21. Nurse's notes were not documented by exception including new orders as indicated above or related to the open areas on the RLE.	A 290		

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A 290	Continued From page 14 3. Record review on 8-12-21 and 8-16-21 of Tenant #3's file revealed a Physician Order document indicated Tenant #3 had increased bilateral knee pain and ambulation was difficult due to her pain. Orders were received to increased Voltaren gel to affected area three times daily and increase Tylenol ER to take two tablets (650 milligrams each) every 6 to 8 hours for pain, with a maximum of three doses in 24 hours, dated 7-21-21. Continued record review indicated a PCP Progress Note (encounter date of 7-22-21) indicated Tenant #3 could "barely walk yesterday" and the pain was localized in her left hip. That morning she said her left hip did not hurt as much and it was her bilateral knees. Further record review revealed there were no nurse's notes (Clinical Notes) for July documented by exception regarding the new orders for Tylenol and Voltaren gel and difficulty with ambulation. 4. When interviewed on 8-16-21 the Administrator confirmed Clinical Notes were provided for the tenants listed above.	A 290		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.	A 350		

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A 350	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans as needed and failed to the have the service plans reflect the service needs of the tenants. This pertained to 3 of 3 tenants reviewed (Tenants #1, #2 and #3). Findings follow: 1. Record review on 8-12-21 and 8-16-21 of Tenant #1's file revealed an Admission Assessment (change of condition) dated 3-26-21 indicated there was an area under Tenant #1's right breast. It was measured and a picture was sent to the primary care provider (PCP). Staff reported a reddened area/sore under the right breast. The area was 2 x 1.75 inches, red and drained a small amount of yellow/tan drainage. A foul odor was also noted. The PCP was notified and an order was received for a nurse to apply Mepilex dressing to the area area and Desitin ointment to the excoriated areas under the breast. The nurse was to change the dressing three times daily. Staff was informed of the area and to avoid getting it wet during showers. Staff would call the nurse if the dressing came off. The assessment indicated Tenant #1 had breast cancer bilaterally and did not want any treatment. Continued record review revealed a Home Health Certification and Plan of Care document reflected Tenant #1 received home health agency (HHA) services with a certification period of 4-13-21 to 6-11-21. The document indicated Tenant #1 was recently diagnosed with terminal breast cancer after staff noticed a large mass and wound on her right breast with lymph node involvement. Tenant #1 was not a surgical candidate and decided not to complete treatment. The right breast wound had grown "significantly" larger in the past few	A 350		

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A 350	Continued From page 16 weeks and required daily dressing changes that were completed by staff or a skilled nurse (SN). The wound measured 9 centimeter (cm) x 6 cm x 0.2 cm. Tenant #1 had no pain related to the wound. A Home Health Certification and Plan of Care document reflected Tenant #1 received HHA services from 6-12-21 to 8-10-21 and was also from 8-11-21 to 10-9-21. The Home Health Certification and Plan of Care document signed on 8-9-21 (8-11-21 to 10-9-21) indicated the wound measured 9 cm x 8 cm and depth was measured at 4 cm; however, might not be accurate due to the slough tissue present. The wound had a moderate amount of bleeding; however, it stopped after several minutes of gentle pressure. If the bleeding was not able to be stopped, Tenant #1 would need to be seen in the emergency room. Tenant #1 had no pain related to wound. Further record review revealed a wound clinic document dated 6-3-21 indicated the wound care goals for Tenant #1 were palliative and not curative. The goal was to minimize complications, prevent infections, manage draining, decrease odor and minimize Tenant #1's pain. Continued record review revealed a PCP Clinic Note dated 7-22-21 indicated Tenant #1's right breast tumor kept eroding and deepening. "She has now a very large cavitating wound with bleeding on the edges and necrosis in the middle. It appears to go clear to the chest wall. Before it got his bad, we had sent her to surgery and oncology to see if anything more should be done with this and no treatments, remedies, or surgery was offered. Wound measurement now is 9 cm x	A 350	The Administrator will conduct a meeting with all nurses On December 3, 2021 to educate staff about service plans. All service plans will reflect all individual services for each tenant. Service plans will be updated with any change in Condition, with updates, or an addition of a services for each Tenant. Service plans will be updated at least annually for each tenant. All staff will be educated about any changes in Service plans. Starting December 6, 2021, the Administrator will monitor compliance by checking service plans with each change in condition for accuracy and include Or any new or additional treatment orders for each tenant. The audits will be completed at least every 60 days and will continue for one year. The audit will be Shared during each QA meeting every 60 days. If audits are not 95% accurate, the audits will continue for another six months.	

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	S0034	A. BUILDING: _____ B. WING _____	08/16/2021

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A 350	Continued From page 17 8 cm and the depth is estimated to be to the chest wall by appearance as it cannot be measured." There was also a new area of skin breakdown. Further record review revealed physician orders indicated the following: - A Physician's Order document dated 4-9-21 indicated there was increased drainage/odor was noted from the right breast and a wound clinic nurse was consulted for recommendations. Orders were received to increase dressing changes to once per day and as needed for drainage, could increase to twice daily for dressing changes if needed. To cleanse the area with mild soap and warm water, rinse and pat dry. Apply Zeasorb AF powder to the surrounding skin and rub in, could put Desitin over the top of the powder if an additional barrier was needed, then cover the wound with abdominal (ABD) pad or gauze and secure with paper tape. -On 4-13-21 a verbal order was received for a SN or AL staff to complete the dressing changes to the right breast once daily and as needed for increased drainage. Cleanse the area with mild soap and warm water, rinse and pat dry. Apply Zeasorb AF to the surrounding skin and rub in. Desitin could be applied over the top of the powder if an additional moisture barrier was needed. The wound was to be covered with ABD pad and secured in place with tape. Monitor for signs/symptoms of infection daily and measure the wound weekly. -On 4-23-21 a verbal order was received to discontinue Zeasorb AF and start Zeasorb powder to the periwound skin once per day.	A 350		

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A 350	Continued From page 18 -On 5-18-21 a verbal order was received to discontinue Zeasorb powder and start Nystatin powder. -On 6-4-21 it was noted the following wound care would be effective until metronidazole was obtained from the pharmacy: once daily to cleanse the area with mild soap and warm water and to rinse and pat dry. Cut Melgisorb Ag in half and apply to the wound bed, Desitin could be applied to the periwound skin if an additional moisture barrier was needed. Cover the wound and Melgisorb Ag with an ABD pad and secure in place with paper tape. When metronidazole arrived the following orders were effective: once daily to cleanse area with mild soap and warm water and to rinse and pat dry. Apply metronidazole gel to the wound bed twice daily for 14 days, Desitin could be applied to the periwound if an additional moisture barrier was needed. Cover with an ABD pad and secure in place with paper tape. (Clinical Notes dated 6-4-21 indicated Duoderm was framed around the wound to act as a barrier for the tape. Tenant #1 did not want to continue using them after the current Duoderm fell off, which was applied at the wound clinic on 6-3-21). -On 7-2-21 a verbal order was received for the SN or AL staff to complete the dressing changes to the right breast once daily and as needed for increased drainage. Cleanse the area with mild soap and warm water, rinse and pat dry. Apply Zeasorb powder to the surrounding skin and rub in. Desitin could be applied to the periwound if an additional moisture barrier was needed. Cover with an ABD pad and secure in place with paper tape. Monitor for signs/symptoms of infection daily and measure the wound weekly.	A 350		

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A 350	Continued From page 19 -On 7-26-21 a verbal order was received for the SN or AL staff to complete the dressing changes to the right breast once daily and as needed for increased drainage. Cleanse the area with mild soap and warm water, rinse and pat dry. Apply Micro-Guard powder to the surrounding skin and rub in. Desitin could be applied to the periwound if an additional moisture barrier was needed. Cover with an ABD pad and secure in place with paper tape. Monitor for signs/symptoms of infection daily and measure the wound weekly. Continued record review revealed SN Clinical Progress Notes indicated the following measurements related to the wound: -On 4-16-21 the wound measured 9 cm x 6 cm x 0.2 cm. -On 4-20-21 the wound measured 9.5 cm x 6 cm x 0.2 cm. -On 4-23-21 the wound measured 9.5 cm x 6 cm x 0.2 cm. -On 4-30-21 the wound measured 10 cm x 7 cm x 0.2 cm. -On 5-7-21 the wound measured 10 cm x 7 cm x 0.2 cm. -On 5-14-21 the wound measured 7 cm x 7 cm x 0.5 cm. -On 5-21-21 the wound measured 7 cm x 7 cm x 0.5 cm. -On 5-25-21 the wound measured 7 cm x 7 cm x 0.5 cm.	A 350		

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A 350	Continued From page 20 -On 6-4-21 the wound measured 7 cm x 7 cm x 0.5 cm. -On 6-18-21 the wound measured 9 cm x 8 cm x 0.5 cm. -On 7-2-21 the wound measured 9 cm x 8 cm (depth unable to accurately measure due to slough). -On 7-9-21 the wound measured 9 cm x 8 cm (depth unable to accurately measure due to slough). -On 7-16-21 the wound measured 9 cm x 8 cm (depth unable to accurately measure due to slough). -On 7-23-21 the wound measured 9 cm x 8 cm (depth unable to accurately measure due to slough). -On 7-30-21 the wound measured 9 cm x 8 cm (depth unable to accurately measure due to slough). Further record review revealed the service plan dated 3-26-21 and 4-9-21 reflected the HHA nurse assisted with labs as needed and assisted with dressing changes. A nurse or AL staff completed dressing changes per physician's order. The service plan was not updated from 4-9-21 to the time of the recertification visit. During the that time period the the wound size increased significantly and the depth of wound was indicated to be to the chest wall. There was bleeding noted at times and there was no information on the service plan regarding what should occur if the wound started bleeding. The service plan also did not indicated who assessed	A 350		

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A 350	Continued From page 21 the wound, the frequency of the assessments or involvement with the wound clinic and palliative wound care. The service plan indicated staff provided assistance with bathing and the service plan did not provide Tenant #1's service needs related to bathing and the wound. 2. Record review on 8-12-21 and 8-16-21 revealed an Admission Assessment (change in condition) dated 7-22-21 reflected Tenant #2 had anti-embolism hose and needed assistance with the hose. It was also noted Tenant #2's right lower extremity (RLE) was pink and had an open area. Continued record review revealed a Physician's Orders document dated 7-21-21 reflected an order for Mepilex border, apply to the wound on the right ankle and change every two to three days. It indicated to continue anti-embolism hose on in the a.m. and off in the p.m. Further record review revealed a fax to the PCP dated 7-27-21 indicated Tenant #2 had three open areas to the RLE. A verbal order was received including for Mepilex foam, cut to apply to open (area) on the RLE and wrap with stretch gauze, then apply an ACE wrap to RLE. Dressing changes were to be completed every other day and anti-embolism hose to the RLE were discontinued. Continued record review revealed the Service Plan was updated on 7-22-21 and reflected staff changed the dressing change every two to three days until area to RLE was healed. The service plan was not updated to reflect the discontinuation of the anti-embolism hose to the RLE.	A 350		

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A 350	Continued From page 22 3. Record review on 8-12-21 and 8-16-21 of Tenant #3's file revealed A Skilled Nurse Visit Note dated 6-15-21 indicated the area between Tenant #3's legs and groin was red, excoriated and sore. The PCP was contacted and a verbal order was received to apply Calmoseptine over the counter (OTC), three times daily to areas until healed and then continue twice daily as a barrier related to incontinence. Continue record review revealed a fax to the PCP dated 6-15-21 indicated Tenant #3 had an excoriated area on her buttocks and groin area. A new order was received for Calmoseptine OTC to the excoriated areas three times per day until healed and then twice daily to prevent skin breakdown. Further record review revealed a Skilled Nurse Visit Note dated 7-16-21 reflected Tenant #3 had an excoriated area approximately 3 cm x 4 cm on her buttocks. Calmoseptine was applied two to three times daily with improvement. Continued record review revealed a Physician Order document indicated Tenant #3 had increased bilateral knee pain and ambulation was difficult due to her pain. Orders were received to increase Voltaren gel to the affected area three times daily and increase Tylenol ER dosing dated 7-21-21. Further record review indicated a PCP Progress Note (encounter date of 7-22-21) indicated Tenant #3 could "barely walk yesterday" and the pain was localized in her left hip. That morning she said her left hip did not hurt as much and it was her bilateral knees.	A 350		

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A 350	Continued From page 23 Continued record review revealed the Service Plan dated 5-21-21 was not updated to reflect Tenant #3's excoriated area and treatment and did not reflect Tenant #3 had bilateral knee pain that at times affected her ambulation. 4. When interviewed on 8-16-21 at 3:11 p.m. the Administrator indicated the most current service plans were provided for the tenants listed above.	A 350		