STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165484	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke Lutheran Nursing Home	1301 Saint Luke Drive Spencer, IA 51301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on observations, interviews, clinical record review, and facility policy, the facility failed to provide dignity by consistently knocking on residents ' doors before entering. The facility reported a census of 67 residents. Findings Include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #4 scored 14/15 on the Brief Interview for Mental Status (BIMS) indicating the resident is cognitively intact. Resident #4 on 8/19/24 at 1:50 PM stated staff do not knock prior to entering her room or announce themselves. The resident stated staff just walk in, do whatever they want, and give orders. Continuous observation on 8/20/24 at 9:49 AM identified Staff H, Certified Nursing Assistant (CNA), Staff I, CNA/Certified Medication Aide (CMA), and Staff J, CNA, delivering towels. The staff were entering rooms on the East Hallway without consistently knocking on the residents ' doors or announcing their entrance. On 8/21/24 at 7:58 AM observed Staff K, CNA, enter a resident ' s room without knocking or announcing her entrance. On 8/21/24 at 12:45 PM the Director of Health Services (DHS) indicated staff should knock on all resident doors prior to entering. The DHS stated staff should wait for response from a resident before entering. The facility provided document, Residents ' [NAME] of Rights revised 11/16, revealed the facility must treat each resident with dignity, respect and care. The facility must provide a homelike and comfortable environment, and the residents have a right to personal privacy.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER St Luke Lutheran Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 Saint Luke Drive Spencer, IA 51301	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on record review, interview and policy review the facility failed to obtain complete resident records. A facility form titled: Authorization for Withholding CPR (Cardiopulmonary Resuscitation) did not include a date, or physician signature and/or a witness signature for 4 of 27 reviewed, (Residents #3, #23, #2 and #121) . The facility reported a census of 67 residents. Findings include: 1. According to the Face Sheet for Resident #3, he was admitted to the facility on [DATE] with a Do Not Resuscitate (DNR). Do not attempt to restore heartbeat and breathing following a cardio pulmonary arrest. A form titled; Authorization for Withholding CPR signed by the resident, included a handwritten note, I want CPR and the writing was scribbled out. The resident's signature and witness signature were not dated. Staff failed to include the code status in a request for signature fax to the doctor dated [DATE]. Item #8 was written: request (blank space) status. 2. The Face Sheet for Resident #23 showed that she was admitted on [DATE] with a code status of DNR. The Authorization for Withholding CPR was signed by the resident and a witness, but it was undated. 48004 3. Review of Resident #2 ' s Electronic Health Record (EHR) revealed a document titled, Face Sheet that indicated Resident #2 had an advanced directive for do not resuscitate. Review of a facility provided undated document titled, Authorization for Withholding CPR, revealed Resident #2 ' s Guardian had signed the form and was the only signature on the form with no date. This document further revealed that the form had no physician signature and no witness signature or dates. 4. Review of Resident #121 ' s EHR document titled, Face Sheet, revealed that Resident #121 had an advance directive for do not resuscitate. Review of a facility provided document titled, Authorization for withholding CPR, revealed Resident #121 ' s Durable Power of Attorney (DPOA) had signed the form with no witness signature or physician ' s signature present. This document further revealed a date of [DATE] was written on the date space by the witness signature. Review of a facility provided document titled, Authorization for Withholding CPR dated [DATE] revealed: a. Upon admission the facility will ask about the resident ' s directives. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. They will be given the opportunity to determine whether they wish for CPR or to withhold CPR. c. After signing the document, it will be sent to the physician for signature. d. The CPR request will be placed in the resident ' s chart and replaced when the signed physician sheet is returned to the facility. e. Code status will be documented in E.H.R. as well as the document will be scanned into the record. g. The Unit Managers/Social Service Director will be in charge of obtaining the resident signature and dating it.

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NAME OF PROVIDER OR SUPPLIER St Luke Lutheran Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 Saint Luke Drive Spencer, IA 51301	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on observations, staff interview, clinical record review, and policy review the facility failed to review and revise the care plan for 1 of 24 residents reviewed (Resident #30). The facility reported a census of 67 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #30 scored 3/15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident completed rolling in bed independently. Section J revealed Resident #30 had occasional pain. Section M of the MDS revealed the resident had 1 or more pressure ulcers/injuries that were not healed. The document indicated the resident had 1 unstageable pressure injury presenting as deep tissue injury. Resident #30's Care Plan revealed the resident has the potential to bruise easily and is at risk for skin breakdown. The document provided approaches for staff including: ensuring heels are placed in boots to prevent pressure. Resident #30's Medication Administration Record (MAR)/Treatment Administration Record (TAR) for 8/24 revealed application of skin prep to the right heel twice daily. The nursing staff signed off on the treatment for 39/41 opportunities. The document also revealed the placement of heels in inflatable boot(s), both heel(s), to prevent pressure with the first date of 6/1/24. Review of the document further revealed staff signed off on the treatment for 39/41 opportunities. Observed on 8/19/24 at 12:55 PM Resident #30's right (R) foot in a boot and the left (L) foot in a regular shoe. Observed on 8/20/24 at 10:02 AM Resident #30's R foot in a boot and regular shoe on the L foot. Observed on 8/21/24 at 6:54 AM Staff L, Registered Nurse (RN), complete wound care to Resident #30's R heel. Upon removal of Resident #30's bed covers observed a single boot on the resident's right foot. Staff L completed the appropriate wound care, replaced the R boot and left the room. Staff L stated Resident #30 came back with the wound to the heel and only wears a boot on the R foot. On 8/20/24 at 10:20 AM Staff M, Licensed Practical Nurse (LPN), stated Resident #30 came back from the hospital with spots on his heels. The staff stated the L heel had healed and the R heel is close. Staff M stated the resident only wears the R boot during the day when he is up and just sitting. The resident may wear regular shoes when ambulating with staff. On 8/20/24 at 12:50 PM the Director of Health Services stated the Care Plans and the TARs should correlate together. If a resident had a positioning device referenced on the TAR it would be expected to be on the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided document, Care Plans, Comprehensive Person-Centered revised March 2022, revealed the MAR/TAR will be considered part of the ongoing Care Plan. The document further revealed the care plan should include services required to attain or maintain the resident's highest level of physical well-being.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interviews and record review the facility failed to follow the interventions and physicians' orders to prevent worsening of pressure ulcers for 2 of 3 residents reviewed, (Residents #64 and #30). Resident #64 had a treatment order for a chronic heel ulcer and the treatment was not followed. Resident #30 had an order to place boots on both feet to prevent worsening of ulcers. Staff were applying a boot to the right foot only. The facility reported a census of 67 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #64 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability). She required partial assistance with toileting, dressing, and transfers. Resident #64 had an unhealed, unstageable pressure open area on her left foot and staff were to apply a dressing on the foot. The Care Plan last updated on 8/8/24, showed the resident had pain related to cancer and was having a hard time moving. She was an assist of one with the wheeled walker, and was admitted to Hospice services on 8/8/24. Staff were to follow wound care orders, as she was being treated by wound care nurse for stage 3 pressure to left heel, and to follow recommendations. Heel protector boot was to be applied when in chair and bed, remove when up. A review of the electronic chart revealed the following Physicians' Orders: a. On 4/16/24, apply waffle boots bilateral at all times except while walking. b. On 6/11/24, cleanse left heel ulcer with sterile saline apply small amount of iodosorb (gel containing substance that helps clean wounds) into the wound. Apply calcium alginate, cover with polymem, (soft absorbent dressing with moisturizing and wound cleansing properties) secure with roll gauze and tape. c. On 7/24/24, cleanse left lateral foot ulcer with sterile saline, apply polymem and secure with medipore (soft, surgical tape) daily. On 8/19/24 at 2:58 PM, Resident #64 was in bed sleeping on her back, she had gripper socks on her feet, and there was a blue heel protector boot in the recliner on the opposite side of the room. On 8/20/24 at 5:59 AM, the blue boot was still in the recliner. The resident was in bed on her back sleeping. On 8/20/24 at 6:20 AM, Staff S, Licensed Practical Nurse (LPN) said that the order was to leave the left heel Open To Air (OTA) so she wouldn't be doing any treatments to the residents foot. On 8/20/24 at 9:25 AM, Staff T, CNA, prepared to give the resident a bed bath. She was sleeping and did not respond when addressed. The boot was still in the recliner. The resident did not have anything on her feet and as Staff T lifted her left foot, it was revealed that she had two sores; one just below the small toe and spot on the heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Treatment Administration Record (TOA) showed that in the month of August, the treatment was not completed and the foot was left open to air. On the 6th and 7th of August the treatments were not signed off as having been completed. On 8/21/24 at 10:15 AM, the Director of Nurse (DON) said she would expect staff to complete orders as written. 49628 2. According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #30 scored 3/15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident completed rolling in bed independently. Section J revealed Resident #30 had occasional pain. Section M of the MDS revealed the resident had 1 or more pressure ulcers/injuries that were not healed. The document indicated the resident had 1 unstageable pressure injury presenting as deep tissue injury. Resident #30's Physician Orders revealed skin treatment: placing heels in inflatable boot(s), both heel(s) to prevent pressure with the first date 6/1/24. The document also revealed to apply dry dressing to the right hip for drainage as needed with the first date of 6/4/24. Resident #30's Medication Administration Record (MAR)/Treatment Administration Record (TAR) for 8/24 revealed staff signing that both boots were in place on AM and HS shifts for 39/41 opportunities with 2 blanks on the document. The document also revealed no documentation for dressing on the right (R) hip for the month of August. Observed on 8/19/24 at 12:55 PM Resident #30's R foot in a boot and the left (L) foot in a regular shoe. Observed on 8/20/24 at 10:02 AM Resident #30's R foot in a boot and regular shoe on the L shoe. Observed on 8/21/24 at 6:54 AM Staff L, Registered Nurse (RN), complete wound care to Resident #30's R heel. Upon removal of Resident #30's covers observed a single boot on the resident's right foot. Staff L completed the appropriate wound care, replaced the R boot and left the room. Staff L stated Resident #30 came back with the wound to the heel and only wears a boot on the R foot. Staff L stated there was no wound on the R hip. On 8/20/24 at 10:20 AM Staff M, Licensed Practical Nurse (LPN), stated Resident #30 came back from the hospital with spots on his heels. The staff stated the L heel had healed and the R heel is close. Staff M stated the resident only wears the R boot during the day when he is up and just sitting. The resident may wear regular shoes when ambulating with staff. Staff M stated there was no wound care for the hip as it had been healed. On 8/20/24 at 12:50 PM the Director of Health Services stated if a resident had a positioning device referenced on the TAR it would be expected to be followed.

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NAME OF PROVIDER OR SUPPLIER St Luke Lutheran Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 Saint Luke Drive Spencer, IA 51301	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interviews, video and record review, the facility failed to account for the whereabouts of 1 of 1 resident reviewed (Resident #16), and failed to ensure that the door alarms were activated. The facility failed to transfer correctly 1 of 1 resident reviewed for a transfer with a sit to stand lift, (Resident #23). On the evening of 5/7/24, Resident #16 used the handicap button, that did not trigger an alarm, to exit through the front door at 7:20 PM. A staff member from the assisted living facility returned him to the nursing home at 10:10 PM. Nursing home staff were unaware that he had been gone for over 2 hours and that he had fallen during his time outside. Staff later found that the alarm to the front door had been turned off earlier that evening. This failure caused an Immediate Jeopardy to the health, safety and security of the residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of May 7, 2024 on August 21, 2024 at 2:15 PM. The facility staff removed the Immediate Jeopardy on August 21, 2024 through the following actions: a. Contractor Knight Protection called to install new alarm system at front door with a key pad and code for anyone exiting the facility. b. Wanderguard System (WGS) was always in working order for those residents assessed to be at risk for elopement. c. Education: Wandering and Elopement in Long-Term Care was assigned to employees. d. Color placard placed at alarm panels at both Nurses' Stations regarding shutting off alarms. e. Employee that turned off the alarm on date of incident was disciplined. f. Director of Nursing had a private message via private FaceBook to nursing employees regarding elopement. The scope lowered from a J to D at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility reported a census of 67 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #16 had a Brief Interview for Mental Status (BIMS) score of 12 (moderate cognitive deficit). He was independent with eating, toileting, dressing, hygiene and walking with the use of a walker. His diagnosis included; seizure disorder, traumatic brain injury, anxiety disorder, and bradycardia. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Care Plan updated on 7/23/24, showed Resident #16 preferred to spend time in his room. Staff were to offer to take him outside to tend to the garden when appropriate. The resident had a history of a traumatic brain injury and had periods of confusion and difficulty organizing his thoughts and communicating needs. Resident #16 had the potential to fall down and get hurt, staff were directed to remind him to ask for help. He tended to lose his balance and would fall or bump into things. On 5/7/24 he had a WG placed to his right ankle and it was removed on 6/19/24. Staff were to monitor for attempts to leave facility and replace if needed. Encourage him to ask for staff assistance if he wants to go outside. Encourage to let staff know when leaving facility with family or friends not to leave facility on his own without staff knowledge. On 8/19/24 at 12:41 PM, Resident #16 was sitting in a recliner in his room. He pointed out at the bird feeder outside his window, and talked about migration of different birds. He said that the staff treat him well, but got in trouble when he went outside without them knowing. He said he wanted to put seed in the bird feeder but nobody wanted to go with him. It was 7:00 at night I sat out there and listened to the birds. He said that he was outside for about 2 hours and then he decided that he better come in because it was getting dark. He said that he was able to leave through the front entrance undetected by hitting the button so the alarm wouldn't go off. A facility investigation showed that on 5/7/24, Staff C Licensed Practical Nurse (LPN) reported that she gave Resident #16 medication at 7:04 PM and he asked her to fill up his bird feeder outside his window. She said she would put in a maintenance request to have that done in the morning. At 10:10 PM, Staff G, Personal Assistant (PA) from the Assisted Living (AL) building brought Resident #16 back to nursing home. He had entered the front door of AL and told Staff G that he needed help finding his room. She then walked him back to the nursing home. At 10:15 PM, Staff C noted that he did not have his walker and he commented to the staff that he went to fix his bird feeder. He was found to have an abrasion to left face, left wrist and both of his knees. At 11:00 PM Staff C went around the nursing home and checked exits and alarms and noted that the front door alarm was bypassed. The resident's walker was found by the front door. A Nursing Note dated 5/8/24 at 2:06 AM, showed that, initially, Resident #16 told the nurse that he hadn't fallen while he was outside. Later, when the nurse noticed a small abrasion to the left side of his face, under his glasses frame, he admitted that he had fallen and had a difficult time getting back up. He also had small abrasions to the left wrist, left knee above and below the knee cap and one to the right knee. An Elopement Risk assessment dated [DATE], showed Resident #16 was not at risk for elopement. An intervention was later added to the document reading: resident did have a WG in place after he went out of the facility without notifying staff, it was intentional that he went outside, and staff is aware to keep track of his whereabouts, WG had been removed. The following signed, written staff statements were included in the facility investigation of the incident from the evening of 5/7/24: a. Staff V, Certified Nurse Aide (CNA) was working that night, giving baths and putting residents to bed. She did not see the resident before he left the building and did not hear any alarms. b. Staff U, CNA did not see the resident or hear alarms. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Staff W, RN did not see the resident or hear alarms. d. Staff X, Certified Med Aide (CMA) did not hear an alarm or see the resident before he left the building. Further investigation revealed that a family had left the facility around 8:00 PM, and the front door alarm went off. Staff E, CNA, indicated to Staff A that it was all clear and it was okay to turn the alarm off so she switched it off. Staff A thought she had turned it back on. Staff were educated and reminded that door alarms were to be turned on at all times, and hourly rounding was to be completed on resident per facility policy. On 8/20/24 at 6:05 PM, Staff G Personal Assistant (PA) in the AL building said that she was just starting her shift (10p-7a) when Resident #16 came to the South door. She said that it was dark outside, he was able to enter by pushing the handicap button. She asked him if he needed help and he said that he needed help finding his room so she walked him over to the nursing home. The only thing he said to her was it's buggy out there. He didn't say that he fell or what he was doing outside. It was chilly, and he was wearing a short-sleeved shirt, pants and shoes. One of his shoes was untied so she tied it for him. He had glasses on, and seemed to be walking okay without assistance. In an observation on 8/21/24 at 8:49 AM, it was found that the outside area from the front door of the nursing home to the assisted living door was about 500 feet through the grass. There were a couple of hills and a valley with rough, uneven ground. A review of a video from the front door of the facility revealed that on 5/7/24 at 7:20 PM Resident #16 walked to the door with his walker, pushed the handicap button and exited the building. On 8/19/24 at 7:20 PM Staff F LPN said that Resident #16 knew that he could just hit the handicap button and the front door would not alarm. He would go out with family quite often so he knew the routine. He wasn't a risk before, didn't wander or check doors, and he was pretty independent around the facility. On 8/20/24 at 8:45 AM, Staff C, LPN said she didn't know how long Resident #16 may have been outside or where he actually went during that time. She didn't think he ever made it to the bird feeder. When Staff G brought him over from Assisted Living, he said that he hadn't fallen. She took him to his room and helped him into the recliner. That's when she noticed he had a scratch near his eye, it was difficult to see behind his glasses. She noticed his knees were dirty and that's when he admitted that he had fallen. Staff C did not remember hearing an alarm. When the resident had been brought back to the facility, she called the supervisor on duty, and she directed her to go around and check all of the alarms. The northeast nurse station alarm for the front door had been turned off. She did not know how long it could have been off, someone cleared it and didn't turn the switch back on. On 8/21/24 at 5:50 AM, Staff A, CNA, said that she worked the night that Resident #16 got out. She did not see him leave or know that he was gone. Earlier in the evening, the alarm had gone off and another employee had told her it was clear so she shut the alarm off. I thought I turned it back on but apparently not. The other staff member could see the front door and the nurses' station where Staff A was standing, and she gave her the okay to turn it off. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/21/24 at 4:30 PM, the Director of Nursing (DON) said that after the incident with Resident #16, she reinstituted the hourly rounding. This was a process where the staff document that all residents are accounted for on an hourly basis. She said that they had used in the past, but most recently, it hadn't been followed. On 8/22/24 at 6:58 AM, the DON said that they had a process for residents and families to sign out so they know where they are, but it wasn't being used and they needed to reeducate staff and families about using that. On 8/21/24 at 3:49 PM Staff Z CNA works PRN. she has worked some evening shifts and from 6-9 PM, most of their time is spent getting residents to bed and it's a very busy time. They try to get to the rounding but sometimes there was just one CNA per hallway and one floater. On 8/21/24 at 3:45 PM, Staff X said that on the overnight/evening shift is a very busy time with getting residents too and from meals, and then getting them ready for bed. From 7 PM-10 PM was the busiest time for resident cares. According to a facility policy titled: Wanderguard System/Door Alarm System, Revised on 8/20/24. The front door was alarmed and you must push the red button to get into the facility. When exiting a code must be punched in before exiting. All door alarms need to physically be checked when sounding to assure that a resident was not leaving and not just turned off at the nurses' station. The policy indicated that staff would perform hourly rounding on residents. 2) According to the MDS dated [DATE], Resident #23 had a BIMS score of 14 (intact cognitive ability). She required substantial assistance with dressing, toileting hygiene, sit to stand and toilet transfers. Diagnosis included diabetes mellitus, anxiety disorder, muscle weakness and chronic pain. The Pare plan updated on 2/7/24, showed Resident #23 used a power scooter for mobility and an EZ stand mechanical lift for transfers. On 8/19/24 at 12:54 PM, Staff Y, CNA prepared to transfer Resident #23 from the wheel chair to the recliner with the Sit to Stand mechanical lift. She attached the sling and strapped the resident's legs to the platform. Several times, she reminded the resident to stand up straight. Once she was in the standing position, Staff Y failed to tighten the belt around the torso. On 8/21/24 at 10:12 AM, the DON said that the staff were taught upon orientation on safe transfers. She acknowledged the risks if/when the buckle on the Sit to Stand was not tightened, especially with a weaker resident. According to the user [NAME] for the Sit to Stand mechanical lift, page 6; as the patient is being raised, simultaneously tighten the safety strap buckled around the torso.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke Lutheran Nursing Home	1301 Saint Luke Drive Spencer, IA 51301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004 Based on clinical record review, observations, resident interviews, staff interviews, and policy review the facility failed to provide respiratory care and services in accordance with professional standards of practice for 4 of 4 residents reviewed (Residents #11, #21, #33, and #41) requiring the use of oxygen. The facility reported a census of 67 residents. Findings include: 1. Review of Resident #11 ' s Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition. The MDS further revealed diagnosis of chronic obstructive pulmonary disease, and dyspnea (shortness of breath). During an interview 8/20/24 at 9:27 AM with Resident #11 revealed that the Resident could not recall when the oxygen tubing was last changed for her. Resident #11 further revealed that it felt as if it had been awhile since it was last changed. On 8/20/24 at 9:28 AM an observation revealed Resident #11 ' s oxygen tubing was dated 6/2/24. 2. Review of Resident #33 ' s MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognition. Review of Resident #33 ' s Electronic Health Record (EHR) document titled, Physician ' s Orders dated 6/20/24 revealed an order to apply oxygen 1-2 Liters (per nasal cannula), as needed to keep oxygen levels equal to or greater than 90%. During an interview on 8/19/24 at 12:02 PM with Resident #33 revealed the Resident could not recall when the tubing was changed. Resident #33 further revealed it had been a while ago. During an observation 8/19/24 at 12:02 PM Resident #33 was observed to be wearing a nasal cannula. Oxygen tubing was observed to have no date on it at this time. 3. Review of Resident #41 ' s MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognition. The MDS included diagnoses of coronary artery disease, and heart failure. Review of Resident #41 ' s EHR document titled, Physician ' s Orders dated 6/20/24 revealed an order to apply oxygen 1-2 liters per nasal cannula. Keep oxygen levels greater than 90% every shift. During an observation 8/19/24 at 11:43 AM Resident #41 was observed to be on oxygen via nasal cannula. It was observed at this time that the oxygen tubing was dated 3/2/24. Review of Resident #41 ' s Treatment Administration Record (TAR) dated August 2024 showed an order to change oxygen cannula one time per week on Tuesday nights. The TAR further revealed that this was not signed on 8/17/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/20/24 at 9:32 AM with Staff N Licensed Practical Nurse (LPN) revealed oxygen tubing is to be changed once a week. Staff N stated that she personally dates the tubing, and the TAR has areas to initial when completed. Staff N then revealed the tubing is usually changed on overnights on Saturdays. Staff N stated her expectation would be for the oxygen tubing to be changed weekly per the orders. During an interview on 8/20/24 at 9:41 AM with the Director of Nursing (DON) stated oxygen tubing should be changed, labeled, and dated as ordered. The DON then revealed the facility does not have a policy related to oxygen tubing being changed, but the facility does follow professional standard. 49628 4. The MDS assessment dated [DATE], documented Resident #21 had a BIMS score of 12/15 indicating moderate cognitive impairment. The MDS documented diagnoses that included coronary artery disease (CAD), heart failure, neurogenic bladder, and benign prostatic hyperplasia. Resident #21 required oxygen. The Medication Profile Report Dated 5/29/24 revealed Resident #21 had orders for 2 Liters (L)/Nasal Cannula (NC) or mask to keep saturations above 90%; oxygen 1-5L/minute (min) per NC as needed for comfort - intermittent or continuous. Resident #21 ' s MAR/TAR revealed an order for changing nebulizer mask/tube/tubing 1x week with the first date 8/27/24, entered on 8/20/24. The document further revealed administration of oxygen 1.0 L/min - 5.0 L/min (per nasal cannula)>or equal to 90% as needed on the first date 5/29/24 (for comfort), entered on 5/29/24. The document revealed no signatures by staff for the resident needing oxygen for the month of August. Resident #21 ' s Care Plan revealed an approach of application of oxygen per primary care provider ' s orders, allow rest periods and to notify the nurse if the resident complains of shortness of breath. Observation on 8/19/24 at 12:51 PM revealed the resident on oxygen via nasal cannula. The oxygen tubing from the concentrator showed a changed date of 7/28/24. Observation on 8/20/24 at 9:37 AM revealed oxygen tubing on the concentrator dated 7/28/24 and nebulizer tubing dated 8/14/24. On 8/20/24 at 10:24 AM and at 1:58 PM Staff M, LPN, stated oxygen tubing and nebulizers were changed once a week on nights. The staff stated it is the facility protocol that the tubing is to be changed weekly and it should be noted on the TAR. Staff M stated it did not matter whether or not the resident received hospice services. On 8/21/24 at 12:50 PM the Director of Health Services (DHS) stated oxygen tubing was to be changed weekly. The DHS acknowledged that earlier in the week that some tubing had not been changed, and the facility had gone through and changed tubing. The DHS stated the facility ordered bright colored stickers for easier notification of dates on the tubing. The staff stated the tubing will now be changed on Tuesdays and it would be noted on the TAR.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on observations, clinical record review, staff interviews and policy reviews the facility failed to implement appropriate hand hygiene and infection control practices to mitigate the spread of pathogens during resident cares (Resident #21, Resident #64). The facility further failed to diminish the risk of spreading SARS-CoV-2 (COVID-19) during an active outbreak. The facility reported a census of 67. 1. The MDS assessment dated [DATE], documented Resident #21 had a BIMS score of 12/15 indicating moderate cognitive impairment. The MDS documented diagnoses that included coronary artery disease (CAD), heart failure, neurogenic bladder, and benign prostatic hyperplasia. The assessment section entitled Functional Abilities and Goals (GG) revealed Resident #21 required extensive assistance to dependent assistance with activities of daily living (ADLs), mobility and transfers. The resident had an indwelling catheter. Resident #21's Care Plan revealed approaches for staff to follow including the resident having a catheter, following enhanced barrier precautions, taking care of catheter equipment, and monitoring output. Observation on 8/21/24 at 9:25 AM Staff H, Certified Nursing Assistant (CNA), and Staff O, CNA, donned appropriate personal protective equipment (PPE) and entered Resident #21's room for catheter and personal cares. Staff O completed catheter care using the left (L) hand to move the resident's skin, testicles, penis, and catheter tubing, while the right (R) hand obtained new disposable wipes from a package multiple times during catheter care. Staff O threw the used wipes across the resident into the trash can. During the same time period Staff H donned the resident's pants and non-skid socks. Staff H and Staff O assisted the resident to reposition to the R and L sides for completion of peri cares. Staff O completed peri cares obtaining wipes and cleaning with the R hand. Resident #21 was incontinent of bowel. Staff O completed removal of the dirty brief, closed it, and handed it to Staff H, who threw it in the trash can. Staff O initiated donning of the adult dependent brief and then removed her gloves. Staff O handed Staff H the dirty gloves, who threw the gloves away, and then handed Staff O clean gloves. Staff O donned the clean gloves without hand hygiene. Staff H and Staff O completed dressing, and transferred the resident to the wheelchair. Resident #21 blew his nose and handed Staff O the dirty tissue. Staff O threw the tissue away, assisted the resident complete upper body dressing, and made the resident's bed. Staff H emptied the resident's catheter, cleaned the urine graduate, placed the catheter in the dignity bag, brushed the resident's hair and cleaned his glasses. Staff H removed her gloves, applied Resident #21's oxygen, removed her gown, and pushed the resident towards the dining room. There was no hand hygiene. Staff O removed her gloves, wound up concentrator tubing, removed her gown and then washed her hands. On 8/21/24 9:58 AM the Infection Preventionist (IP) stated it was expected that every time gloves come off the staff need to complete hand hygiene. The IP stated following peri cares and catheter cares she would expect changing of gloves with hand hygiene before proceeding with other cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/24 at 12:53 PM the Director of Health Services (DHS) stated she would expect gloves to be changed during peri cares when hands became contaminated and before continuing on to other tasks. The DHS stated hand hygiene should occur prior to glove application, between gloves, and at the removal of gloves. The facility document, Infection Control Guidelines for All Nursing Procedures reviewed 1/30/20, revealed all direct control staff must have training on general infection and exposure control issues prior to having direct-care responsibilities for residents. The document further revealed employees must wash their hands with antimicrobial or non-antimicrobial soap and water or use alcohol-based hand rub containing 60-95% ethanol or isopropanol after removing gloves, after handling items potentially contaminated with blood, bodily fluids, or secretions, and before moving from a contaminated body site to a clean body site during resident care. The facility document, Handwashing/Hand Hygiene reviewed 3/10/20, revealed all staff will follow the procedures to prevent the spread of infection. The document also revealed alcohol-based hand rub with at least 62% alcohol or soap and water should be used after removing gloves, before and after handling an invasive device, and is the final step after removing and disposing of personal protective equipment (PPE). 2. Observed on 8/19/24 at 10:30 AM upon entry into the facility a sign posted that stated the facility was in outbreak status and masks must be worn by all healthcare providers and visitors. On 8/19/24 at 2:41 PM Staff R, Infection Technology, entered the conference room from the main hallway, dropped off a computer, and exited the room without wearing a mask. Observed on 8/20/24 at 7:00 AM the Laundry Supervisor and Staff P, laundry, working together without wearing masks. Observed on 8/20/24 at 7:29 AM the Maintenance Director and multiple maintenance/grounds staff gathered in the Maintenance Director's office talking. None of the staff were wearing masks. Observed on 8/20/24 at 11:35 AM the Office Manager walking in the main hallway into the business office without wearing a mask. Observed on 8/20/24 at 4:05 PM Staff Q exiting a room and walking in the hallway with her mask down below her chin. Observed on 8/20/24 at 4:15 PM the IP sitting at a table with the DHS in the DHS's office without a mask. On 8/20/24 at 10:37 AM the IP stated the facility has had 14 residents and 9 staff test positive for COVID-19 with the first resident testing positive on 8/6/24. The IP stated on 8/19/24 the facility had 2 residents and 2 staff test positive for COVID-19. The staff stated the facility is encouraging visitors to wear masks and staff were to wear masks. The IP stated if staff are in offices, they were OK to not wear masks, but they were to wear masks in the halls. The IP voiced that she was not worried about staff not wearing masks around others in an office if there was enough distance. The staff would not elaborate on what enough distance constituted, but would encourage separation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/24 at 12:58 PM the DHS stated masks were to be worn in all resident care areas, including hallways and residents' rooms. The DHS expected staff to wear masks when around other staff even when in offices. The facility document, Coronavirus Disease (COVID-19) - Source Control dated 8/1/23, revealed source control measures are utilized as part of COVID-19 prevention and control measures. Source control included use of well-fitting masks that cover the mouth and nose, and prevent the spread of respiratory secretions when individuals were breathing, talking, coughing, or sneezing. The document disclosed source control may be implemented more facility-wide targeting higher risk areas or resident populations. The document also revealed those working in a facility experiencing an outbreak the universal use of source control may be discontinued as a mitigation measure once no new cases have been identified for 14 days. 41785 3. According to the Minimum Data Set (MDS) dated [DATE], Resident #64 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability). She required partial assistance with toileting, dressing, and transfers. Resident #64 had an unhealed, unstageable pressure open area on her left foot and staff were to apply a dressing on the foot. The Care Plan last updated on 8/8/24, showed the resident had pain related to cancer and was having a hard time moving. She was an assist of one, and was admitted to Hospice services on 8/8/24. Staff were to follow wound care orders for a stage 3 pressure to left heel, and to follow recommendations. The heel protector boot was to be applied when in chair and bed, remove when up. A Nursing Note dated 8/19/24 at 8:27 AM showed Resident #64 tested positive for COVID-19. She was experiencing shortness of breath, chills, and muscle pain. On 8/19/24 at 2:58 PM the entrance to the room for Resident #64 was covered with plastic and there was a bin outside the door with Personal Protection Equipment (PPE). The resident was in bed sleeping on her back and did not respond when addressed. On 8/20/24 at 9:25 AM, Staff T, Certified Nurse Aide (CNA) provided a bed bath for the resident. Staff T cleaned the residents face, arms, back legs and peri area with disposable clothes. She provided the entire bed bath without having changed her gloves, she pulled the covers back over resident and touched many surfaces before removing gloves and gown. Staff T left the room without washing her hands and used the hand sanitizer in the hallway.