STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165591	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spurgeon Manor	1204 Linden Street Dallas Center, IA 50063

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40905 Based on resident record review, staff interview, and facility policy review the facility failed to develop and implement a comprehensive person-centered care plan to include a resident's repeated hospitalization s for pneumonia for 1 resident (Resident #36) and high-risk medications for 2 residents (Resident #7 and #35) of 15 residents reviewed for care plans. The facility reported a census of 49 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #36, dated 8/29/24, included diagnoses of pneumonia, Coronary Obstructive Pulmonary Disease, and respiratory failure. A Brief Interview for Mental Status (BIMS) score of 15, indicated no cognitive impairment for decision-making. Resident #36's hospital admission records documented resident admitted to the hospital on 4/15/24 for pneumonia of left lower lobe due to infectious organism and sepsis (infection in blood). Resident #36's hospital records documented resident admitted to the hospital on 6/11/24 for an abscess of left lung with pneumonia. Review of Resident #36's Care Plan initiated 11/27/23, lacks inclusion of repeated hospitalization s for pneumonia and monitoring of respiratory failure. 2. The Quarterly MDS for Resident #35, dated 9/19/24, included diagnoses of diabetes, anxiety disorder, and neurocognitive disorder with lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning, and independent function). A BIMS score of 4, indicated severe cognitive impairment for decision-making. Resident #35's Order Summary Report documented the resident received Lantus(insulin)injections 1 time daily for diabetes with start date of 8/15/24, and Sertraline (antidepressant medication) for anxiety and negative behavior with start date of 8/8/24. Review of Resident #35's Care Plan, initiated 3/12/24 with revisions on 9/3/24, lacked documentation of focus for diabetes with use of insulin and monitoring for high and low blood sugars, and for the use of an antidepressant with monitoring for side effects and usage. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	46875 3. Resident #7's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS identified Resident #7 required substantial/maximal assistance with bed mobility, and was dependent on staff for transfers and toileting. Resident #7's MDS included diagnoses of hypertension (high blood pressure), renal disease (kidney), and anxiety disorder. A Physician order dated 8/5/24 directed staff to administer Lasix (diuretic) 20 mg (milligrams) one tablet two times a day for bilateral lower extremity edema and coarse crackles in the lungs. A Physician order dated 4/17/24 directed staff to administer Apixaban (anticoagulant) 5 mg one tablet two times a day for anticoagulation, which contained an alert black box warning. A Physician order dated 3/19/24 directed staff to administer Sertraline HCL (antidepressant) 25 mg one time a day for anxiety. Review of Resident #7's Care Plan with a revision date of 10/1/24 lacked information about the usage of the diuretic, anticoagulant and/or antidepressant medications, potential side effects and what to monitor for while taking the high risk medications. On 11/6/24 at 3:15 PM, the MDS Coordinator acknowledged and verified the high risk medication for Resident #7 were not addressed on the care plan. She stated she must have missed adding those medications to the care plan. On 11/6/24 at 3:32 PM, the ADON (Assistant Director of Nursing) reported she would expect the care plans to address the usage of high risk medications and respiratory care/services. A facility policy titled Care Plan Revision Upon Status Change 10/12/2023 documented the purpose of the procedure was to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. The policy further documented the comprehensive care plan to be reviewed, and revised as necessary, when a resident experiences a status change. The policy directed the following procedure for reviewing and revising the care plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with the new or modified interventions. e. Staff involved in the care of the resident will report resident response to new or modified interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident ' s care. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs.

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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** 49056 Based on observations, record review, staff interviews and facility policy the facility failed to properly prevent an unstageable pressure ulcer to bilateral heels consistent with professional standards of practice for 1 of 1 residents reviewed (Resident #28). The facility reported a census of 49 residents. The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The Annual Minimum Data Set (MDS) assessment tool dated 9/19/24, for Resident #28 documented diagnoses that included Non-Alzheimer's dementia, arthritis, anxiety and depression. The MDS showed a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The MDS identified the resident as at risk for pressure ulcers. The MDS also identified the facility had placed a pressure reducing device in the resident's chair and pressure reducing device for the bed. The MDS identified Resident #28 is dependent on transfers, bed mobility, toileting and dressing. Resident #28's care plan revised on 5/10/24 contained the following information; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Resident #28 is at risk for impaired skin integrity related to limited mobility and catheter tubing. The care plan directed staff to: apply lotion to bilateral upper extremities two times daily as I allow assist with bathing at least two times per week. encourage to call for assistance to help with bed positioning geri-sleeves or long sleeves at all times as I will allow a pressure reducing mattress on my bed. have an gel cushion in my recliner The resident's Care Plan lacked preventative interventions to help prevent the unstageable pressure areas specific to the right and left heels. The Resident's Care Plan Identified risk for impaired skin integrity related to limited mobility with initiated date of 10/09/2023. The facility provided Braden Scale dated 9/18/24 showed Resident #28 scored a 15 which indicates at risk for pressure ulcers. Review of Resident #28's progress notes revealed the following; 1. On 10/27/24 at 11:55 AM, Resident #28 complained of right heel pain, noting two small areas on the right heel, the area is red to brown in color. New interventions started to apply bunny boots while sitting and lying down and to float heels at all times. Skin prep applied per geriatric protocol. 2. On 10/28/24 at 3:07 PM, Resident #28 continues to have sore areas on both heels. Received fax back with an ok to apply skin prep twice a day and float heels. 3. On 11/4/24 at 12:30 PM revealed Resident #28 was seen by a Nurse Practitioner stating the pressure ulcer of right heel and left heel are unstageable, continue skin prep twice a day to both heels, float heels at all time when sitting/lying down and utilize bunny boots when in bed/chair. The facility provided Skin & Wound Evaluation revealed the following area measurements; 10/28/24 Left heel - 1 centimeters (cm) x 1 cm (length x width) 10/30/24 Left heel - 0.8 cm x 1.0 cm 11/7/24 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Left heel - 0.9 cm x 1.0 cm 10/27/24 Right heel - 1.2 cm x 0.8 cm 10/30/24 Right heel - 1.4 cm x 0.8 cm 11/7/24 Right heel - 1.3 cm x 0.5 cm The evaluations documented unknown as to how long the in house acquired pressure wounds had been present to the right and left heels. Review of [NAME] Manor fax sheet dated 10/28/24 revealed new orders from physician as to follow geri protocol, apply skin prep twice daily on both heels, float heels all times when sitting/lying down and apply bunny boots to bilateral heels. Review of wound physician Doctor [NAME]'s progress notes dated 11/6/24 revealed right heel measures 1 cm x 1 cm, skin is intact with purple/maroon discoloration. Left heel measures 2 cm x 2 cm, skin intact with purple/maroon discoloration. New order to do betadine twice daily for 30 days with gauze island with border apply twice daily for 30 days. Interview on 11/6/24 at 3:30 PM with Doctor (Dr) [NAME] stated Resident #28 was a new patient and the facility asked to consult today. Dr. [NAME] reported that Resident #28 has two deep tissue injury (DTI's) to her right and left heel. Dr. [NAME] reported the areas are not open, one is softer than the other one. Dr. [NAME] reported she gave new orders to do betadine with border gauze and hopefully in a week the betadine will dry up and I will be able to peel off the scab area. Dr. [NAME] reported we figured out that Resident #28 was putting pressure down on the foot stool and in the wheelchair. Dr. [NAME] stated if she did have to say she thought they were unavoidable. Facility provided a policy named Skin and Wound Protocol with an effective date of 10/10/24 revealed the purpose is to identify residents at risk for potential breakdown or ulcerations, to prevent breakdown of tissue ulcerations and to provide treatment that promotes prevention and healing of skin issues. Staff will institute a plan for any resident who has potential for skin breakdown or whose condition is deteriorating. This may include: a. Turn and reposition every 2 hours as appropriate b. Pressure reduction surfaces for beds, wheelchairs when appropriate c. Floating areas of concern such as heels when appropriate d. Separation of body prominences with a pillow or other pressure reduction device when side lying or as appropriate (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Use of elbow or heel protectors when appropriate f. Promotion of clean, dry, and well moisturized skin g. Following Registered Dietician recommendations (such as the NIP Program) to promote optimum nutrition when possible h. Reduction of shearing force by using appropriate body mechanics when moving, turning, or repositioning a resident. The nurse aides will report any clothing, shoes, braces, and splints that may not be fitting properly to the supervisor or floor nurse. Do not massage any areas of concern as this may cause further tissue damage and breakdown. Encourage residents to change position frequently and ambulate as capable. Keep the bed as free from wrinkles as possible. Nurse aides will complete body audits with bathing and care and report changes in skin condition to the nurse. The nurse will determine if the skin condition is new or needs further intervention. Interview on 11/06/24 at 1:07 PM with ADON stated they talk about skins in a multidisciplinary rounding meeting four times a week and they put interventions in place by that information. ADON revealed interventions that were in place before these areas to Resident #28's heels. ADON stated that Resident #28 had been wearing shoes and put her heels into the recliner. ADON revealed we are now floating and applying bunny boots to her heels. Interview on 11/7/24 at 11:41 PM with the ADON revealed they look at resident's mobility and try to keep them active. We got therapy involved with Resident #28 because she used to ambulate. We have used lotions, and we will utilize a pillow to float their heels if the resident will allow it.