STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E263	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanford Senior Care Sheldon	118 North Seventh Avenue Sheldon, IA 51201

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on observations, record review, staff and family interviews, the facility failed to complete accurate assessments and implement interventions for a resident to prevent the development of a Stage 4 pressure sore for 1 of 3 residents reviewed (Resident #1). Certified Nursing Assistant (CNA) staff identified a reddened area on a resident's coccyx in [DATE] and reported it to nursing staff. The record lacked assessments of the area, notification to the physician and treatment orders. On [DATE] an open area on the coccyx was identified and measured 1cm x1 cm. The facility failed to assess the area, implement interventions, implement treatments and notify the physician and family. On [DATE] the open area to the coccyx measured 1cm x 0.8 cm. The facility failed to assess the area, implement interventions, implement treatments and notify the physician and family. On [DATE] Resident #1 was admitted to the ER with a diagnosis of sacral decubitus ulcer, stage 4. The resident expired on [DATE] the Death Certificate showed immediate cause of death MRSA Cellulitis, buttock, due to sacral ulcer Stage 4. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of [DATE] on [DATE] at 3:52 p.m The Facility Staff removed the Immediate Jeopardy on [DATE] through the following actions: a. All residents received a full body skin review by RN Nurse Supervisor and no additional concerns were identified. b. All nursing staff were reminded of the importance of skin observations and following process on [DATE]. Additional education was provided on [DATE] and [DATE]. Notifications to physicians and family were included in this education and are on skin checklist packets. This was done by the Director of Nursing and or designees. c. Skin processes and status were reviewed at each huddle beginning [DATE] and this will continue using the huddle checklist. This was initiated by the Director of Nursing Services. d. All care plans were reviewed and updated as appropriate on [DATE] by RN supervisors. This was reviewed again on [DATE] by RN supervisors, Social Worker and Activity Director. e. A tracking tool was initiated that will be completed weekly to show all ulcers and surgical wounds. This will be reviewed at the weekly Risk meeting. This will be completed by the RN supervisor after wound rounds are completed. (continued on next page)

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f. A weekly Risk meeting has been established. This meeting will include Administrator, Director of Nursing, RN Supervisors, Social Services, Activity Director, Quality Director, and Infection Preventionist. Residents with skin impairments will be reviewed to assist in identifying further interventions needed. Care plans will be updated with any changes noted. g. Reviews for each resident with ulcers and or surgical wounds will be reviewed daily for signs and symptoms of pain and infection. This will be noted on the residents treatment sheet. h. The Director of Nursing and or RN Supervisors will review the Matrix Even each day to review tasks and assessments that were completed as necessary. i. Audits to ensure skin observations are complete will be conducted weekly for 3 months by the Director of Nursing or designee. j. The tracking tool will be completed weekly going forward to track measurements, treatment and care plan updates. This will be done by an RN supervisor or designee. The scope was lowered from a J to G at the time of the survey after ensuring the facility implemented education and their policy and procedures. The facility reported a census of 48 residents. Findings include: 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: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 MDS assessment dated [DATE]showed Resident #1 scored 13 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.The diagnoses included non-Alzheimer's Dementia, diabetes mellitus and hypertension. The MDS included Resident #1 required partial to moderate assistance from staff for toileting hygiene, bathing, lower body dressing, putting on and taking off footwear, and personal hygiene. The Resident was at risk of developing pressure ulcers or injuries and did not currently have a pressure ulcer or injury and had a pressure reducing device for bed. Review of the Progress Notes revealed the following: On [DATE] at 8:25 a.m., Skin Observation on coccyx done, see observation. On [DATE] at 2:28 p.m., Resident wound on coccyx was bleeding a bit today. Review of the Care Plan dated [DATE] revealed the resident was at risk for pressure ulcer due to moisture. The Care Plan lacked information about any redness or open areas. Review of Bath Sheets revealed the following information: On [DATE]- completed with skin tears written on the sheet with a circle and line drawn to the coccyx area on the body diagram. Reddened areas noted to the buttocks and coccyx area with skin barrier cream applied to buttocks. On [DATE]- completed with reddened areas noted to the buttocks area. On [DATE]- completed with skin tears written on the sheet with a circle and line drawn to the coccyx area on the body diagram. Reddened areas noted to the buttocks and coccyx area with skin barrier cream applied to buttocks. On [DATE]- completed with reddened area noted to buttocks with circle and 2 x's on the buttocks/coccyx area hand written very red and sore. On [DATE]- completed with a reddened area noted to the buttocks with asterisk over the coccyx area. On [DATE]- completed with a reddened area noted to the buttocks and coccyx area with a circle around the coccyx area. On [DATE]- completed with no reddened area noted. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Skin Integrity Conditions assessment dated [DATE] at 10:12 a.m., completed by Staff R, Registered Nurse (RN) revealed a pressure sore to Resident #1's coccyx area that measured 1 centimeter (cm) x 1cm. Interventions listed were pressure reducing device in chair, pressure ulcer care and applications of ointments or medications. Review of the clinical record lacked any documentation of the pressure ulcer or pressure ulcer care started on [DATE] and notification of the physician or family. Review of the Care Plan lacked any new interventions for the care of the identified pressure ulcer. Review of the Skin Integrity Conditions assessment dated [DATE] at 8:22 a.m. revealed a pressure ulcer to Resident #1's coccyx area measuring 1cm x 0.8cm. No further details listed on the assessment. Review of the clinical record lacked any documentation of the pressure ulcer, pressure ulcer care and notification of the physician or family. Review of emergency room Encounter note dated [DATE] at 1:28 p.m., revealed exam of Resident #1 who presents to the emergency room with concerns of hypotension. Initial blood pressure ,d+[DATE]. Fluids were ordered. Diagnosis included pressure injury of buttock, Stage 3 unspecified laterally. The assessment patient is minimally responsive. Findings included: wound present. Large sacral pressure wound characterized by redness, tenderness and purulent drainage. This morning when the staff attempted to get him up, the patient pointed to his bottom and they noticed a sore in the sacral area. Review of hospital Admission History and Physical dated [DATE] at 8:33 a.m., under Assessment Plan Principle Problem with active diagnosis including sacral decubitus ulcer, Stage 4. On the day he was brought to the ER 1 day ago the staff noted sore on his bottom that he pointed to a complaint of pain. Unsure when that was initially noted or felt. Review of the hospital Discharge Summary dated [DATE] at 8:35 p.m., revealed death summary diagnosis included sacral decubitus ulcer, Stage 4. The patient was admitted 2 days earlier for altered mentation and found to have decubitus ulcer and suspected of having sepsis likely from that. The family opted for keeping him comfortable. He was admitted in the care of his pain and discomfort and he died peacefully. The Death Certificate for Resident #1 showed immediate cause of death was MRSA Cellulitis, buttock, due to sacral ulcer Stage 4. Interview on [DATE] at 2:26 p.m., with Staff D, CNA revealed she knew Resident #1 had something on his coccyx area but was not sure what it looked like as there was always white cream on the area when she took care of him. Staff D expressed Resident #1 would complain about pain in his buttocks area. Interview on [DATE] at 2:47 with Staff E, CNA revealed she had seen the area on Resident #1's bottom and reported it to her medication aide that was working that day and she put a cream on the area. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 2:50 p.m., with Staff A, RN revealed she had worked with Resident #1 and had received disciplinary action for a note she started in the Progress Notes and never followed up on the area. Staff A revealed she had seen a red area on Resident #1's buttocks area and had not done any interventions or a skin packet when she observed the area. Approximately a week and half to 2 weeks ago the CNA's told Staff A that Resident #1 had bright red blood on the toilet seat. Staff A had the CNA's give him a bath and when he was done she assessed his buttocks area and no areas were noted at that time. Interview on [DATE] at 3:05 p.m., with Staff F, RN revealed she had not seen the wound on Resident #1's buttocks but staff had reported it to her. Staff F revealed whoever the nurse working the hallway is responsible for the dressings and treatments on the hallway. Staff F had told another nurse to do the treatment but had not followed up with her to ensure the treatment and documentation was completed. Staff F further revealed she passed on to the next shift the concerns with Resident #1's coccyx area. Interview on [DATE] at 9:08 a.m., with Staff B, RN revealed she had cared for Resident #1 and had seen his coccyx area for the first time when it was red and not open but did not document the information. Staff B revealed she had seen the area when it was open and did not document it as she was under the understanding the nurse prior to her was aware of it and was going to document the area. Interview on [DATE] at 9:29 a.m., with Staff C, CNA revealed on [DATE] Staff A, RN had been in the room with the CNA's assisting with transfer and was unable to look at his coccyx area at that time due to resident transferring poorly. Staff C stated she had reported on [DATE] to the nurse the area looked like hamburger but the area was covered in cream and you could see the blood spots in the slits of the cream when she assisted with pulling up Resident #1's pants. Interview on [DATE] at 10:12 a.m., with Staff G, CNA revealed she had seen Resident #1's buttocks area and reported it to superior that day. Staff G described the area as a red openish area on the upper left buttock and on the upper right buttock there were 2 open areas and it was bleeding. The staff came and looked at it but was unsure if she measured the area and applied a duoderm dressing to the area. Interview on [DATE] at 10:21 a.m., with Staff H, CNA revealed Resident #1's buttocks area when he came wasn't very big at all but he did voice concerns of pain in the buttocks area and the area had been progressively getting worse. The last time she had assisted Resident #1 she stated the area on his buttocks looked absolutely awful. Staff H had reported to the nurse on duty the resident's color was off and he looked grey and purple. Staff H described the area was from the coccyx area where there were 2 blisters. On the way down there was bloody skin on both sides of the buttocks and continuing down looked like hamburger and went all the way down to the scrotum. Staff put cream on it as they were not sure what else to do. Staff H explained Resident #1 was incontinent towards the end and when the staff would change his brief it would stick to the area and when removed the resident would moan in pain. Interview on [DATE] at 10:30 a.m., with Staff I, RN revealed she was unaware of the area but wishes she would have known about it sooner. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 10:35 a.m., with Staff J, RN revealed she was unaware of any skin areas on Resident #1 but was aware of the area now. Staff J revealed she understands he had an open area to the buttocks coccyx area and his groin was red and sore. Staff J denied ever seeing the open area to Resident #1 but the CNA had reported it looked like hamburger to her. Staff J revealed when it was reported to her the resident was in his recliner and staff had not cared for him yet and the meals were being served in the hallways so when staff went into assist him she was unable to go as she was assisting other residents. Staff J denied looking at the area when it was reported to her during her shift. Staff J reported she did not report the area to the next shift coming on. Staff J revealed looking back she wished she would have gone in and looked at the area or at least had someone go in and look at the area when it was reported to her. Interview on [DATE] at 1:58 p.m., with the Director of Nursing revealed the facility had nursing staff that received disciplinary action and some were suspended due to not following through with the skin. We are trying to do everything possible to prevent this from occurring again. Review of facility provided policy titled Pressure Ulcers with a reviewed date of [DATE] revealed; A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. Residents will receive appropriate assessments and services to promote and maintain skin integrity. Review of facility provided policy titled Skin Assessment Pressure Ulcer Prevention and Documentation Requirements reviewed [DATE] revealed if a pressure ulcer is identified, cleanse the area prior to observations being made to allow the wound bed and depth to be more accurately observed. The licensed nurse records the location of the area, the measurements, and the ulcer/wound characteristics. Notify the physician/practitioner of the ulcer and resident's condition to obtain orders for a treatment. Notify resident and/or family/representative of the pressure ulcer, orders and planned interventions.