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	10/03/2024

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review, staff and physician interview, the facility failed to notify the physician and family of significant weight loss for 2 of 3 residents reviewed (Resident #14 and #27) and for 1 resident with a choking incident (Resident #27). The facility reported a census of 49 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #14 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident fed herself. The resident had diagnoses including gastroesophageal reflux disease, diabetes, non-Alzheimer's dementia, anxiety and depression. The resident had a weight loss of 5% or more in the last month or a loss of 10% or more in last 6 months, and was not on a physician prescribed weight loss regimen. The clinical record lacked documentation the physician or resident representative were notified of the significant weight loss. On 10/2/24 at 11:15 AM the Dietician stated when a resident had a significant weight loss he would do a dietary assessment and make recommendations if necessary. The DON or MDS Coordinator should notify the physician. On 10/2/24 at 3:13 p.m. the Director of Nursing (DON) stated she couldn't say if the physician or family were notified of the significant weight loss. They met with the dietician for recommendations. The resident did not require a change in dietary interventions at that time. The facility Weight and Height policy dated 9/18/23 identified the purpose included to report changes in a resident's clinical condition (significant weight change) immediately to the physician, the family and to the resident. The policy included the location would immediately inform the resident, consult with the resident's physician and, if known, notify the resident's legal representative when there was a significant change in the resident's weight. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The licensed nurse should notify the director of food and nutrition (dietician) within 24 hours regarding any significant weight change. Significant weight change was defined as five percent in 30 days, 7.5 percent in 90 days and 10 percent in 180 days. The licensed nurse should immediately notify the medical provider regarding any significant weight change (as defined above). 2) According to the MDS assessment dated [DATE] Resident #27 scored 9 on the BIMS indicating moderate cognitive impairment. The resident required partial/moderate assistance with eating. The resident had diagnoses including a stroke, anxiety and depression. The resident had a weight loss of 5% or more in the last month or a loss of 10% or more in last 6 months, and was not on a physician prescribed weight loss regimen. a. The Progress Notes dated 7/18/24 at 2:09 p.m. documented the Dietician held a meeting with the MDS nurse and the Director of Nursing (DON) to discuss the resident's weight loss. The resident had a 9# loss for the previous 60 days. Protein supplement 3 times a day. The clinical record lacked documentation the physician or resident representative were notified of the significant weight loss. On 10/2/24 at 3:13 p.m. the DON stated she couldn't say if the physician or family were notified of the significant weight loss. They met with the dietician for recommendations. b. The Progress Notes dated 9/7/24 at 9:42 a.m. documented a staff member put on the Staff Emergency light in the resident's room and went and found another nurse. The nurse entered the resident's room and found the resident struggling to breathe due to aspiration. The resident's face was turning blue, with lips blue as well. The nurse brought the resident to her side and cleared her airway of saliva and mucus. The resident followed commands throughout the the process. Assessment completed after the resident's airway cleared included crackles in the lung fields and vital signs were checked. At 11:25 a.m. the resident assessed again after the episode of aspiration. The resident alert and oriented to name, and no signs of confusion noted. The resident communicated with clear speech. Vital signs were taken. Lung sounds were clear. The resident's clinical record lacked documentation the facility notified the physician or the resident representative of the incident. On 10/2/24 at 3:13 p.m. the DON stated she did not feel the physician or family needed to be notified of the choking incident. The nurses took care of the situation and followed up a couple hours later and the resident was fine. She did not feel it indicated any further follow up. The resident had trouble swallowing, that's why she had a modified diet. On 10/3/24 at 8:40 a.m. the resident's Physician stated she would expect notification of the significant weight loss and the episode of choking/aspirating. The facility Physician - Family Notification policy dated 9/8/23 identified it would establish a consistent process for notification of resident's family members and resident's attending physician of specific events/situations. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It directed a staff member would immediately contact a resident's emergency contact person and the attending physician in the situations including a significant change in physical, mental or psychosocial status.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to notify the long term care (LTC) Ombudsman of resident hospitalization s for 2 residents reviewed (Resident #4 and #8). The facility reported a census of 49 residents. Findings include: 1) The Resident Census page showed Resident #4 was hospitalized [DATE] and returned 5/29/24, 7/21/24 and returned 7/25/24, and 8/19/24 and returned 8/27/24. The monthly Transfers/Discharges forms provided by the facility for ombudsman notification, lacked the resident's transfers to the hospital. 2) The Resident Census page showed Resident #8 was hospitalized [DATE] and returned 8/18/24. The monthly Transfers/Discharges forms provided by the facility for ombudsman notification, lacked the resident's transfer to the hospital. On 10/3/24 at 9:05 a.m. the Social Worker stated she did not include transfers to the hospital on the monthly notification to the ombudsman. She was not instructed to include those. The facility Ombudsman policy dated 12/6/23 included the ombudsman was an advocate whose goal was to promote the highest quality of life for residents by serving as a communication bridge between the resident and the location. For information regarding state-specific regulations, see website: www.ltcombudsman.org. Navigating the link brought up the National Long Term Care Ombudsman Resource Center CMS S&C Memo, and another a link to the Explanation of Notice of Transfer-Discharge and SQC (May 12, 2017.) The memo documented when a resident was temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident and resident representative as soon as practicable, according to 42 CFR 483.15(c)(4)(ii)(D). Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527 Based on record review and staff interview, the facility failed to assure the Minimum Data Set (MDS) assessment accurately reflected the resident's status for 1 of 17 residents reviewed (Resident #4). The facility reported a census of 49 residents. Findings include: According to the MDS assessment dated [DATE] Resident #4 scored 5 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The MDS documented the resident was not considered by the state Level 2 Preadmission Screening and Record Review (PASRR) to have serious mental illness. The resident had diagnoses including non-Alzheimer's dementia and bipolar disorder. A PASRR Notice of Nursing Facility Approval dated 12/11/18 directed Resident #4 needed the level of services provided in a nursing facility, and specialized services for behavioral health were required. The resident met the criteria for having a diagnosis of mental illness as defined by PASRR. The resident had depressive disorder, bipolar disorder, and dementia. On 10/3/24 at 8:35 a.m. Staff A Registered Nurse (RN) MDS Coordinator stated she did MDS's, as did Staff B RN. Staff A said if a resident had a level 2 PASRR she would answer yes (to the question on the MDS). If they had a level 1 without need for level 2 she would answer no. At 9:40 a.m. Staff A stated the resident did have a level 2 PASRR, and the answer to the question about PASRR would be yes. The facility MDS 3.0 RAI (Resident Assessment Instrument) policy dated 8/27/24 directed each discipline would be responsible for completing its section(s) of the MDS. The MDS coordinator would submit the MDS.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on record review and staff interviews the facility failed to provide professional standards of care by not repositioning a resident with spinal cord dysfunction per provider orders for 1 of 17 residents reviewed (Resident #49). The facility reported a census of 49 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #49 documented diagnosis of traumatic spinal cord dysfunction and an unhealed pressure ulcer. The MDS showed a BIMs score of 15, which indicated no cognitive impairment. The Provider Order for Resident #49 dated 9/4/24 instructed staff to reposition every one hour while in the chair and every two hours while in bed. The Care Plan for Resident #49 instructed staff to turn and reposition the resident every two hours. If the resident refused repositioning, document the refusal. The Care Plan failed to show the most current provider order to reposition every one hour while in the chair and every two hours while in bed. The Repositioning Records for Resident #49 showed the facility failed to change the repositioning schedule to match the providers orders from 9/4/24. The look back period included 9/4/24 through 9/30/24. The following dates showed the facility failed to reposition Resident #49 as ordered: 9/15/24 9/16/24 9/17/24 9/18/24 9/19/24 9/20/24 9/21/24 9/22/24 9/23/24 9/24/24 9/25/24 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/26/24 9/29/24 9/30/24 The Repositioning Records for Resident #49 showed the facility failed to provide repositioning documentation for the following dates: 9/4/24 9/5/24 9/6/24 9/7/24 9/8/24 9/9/24 9/10/24 9/11/24 9/12/24 9/13/24 9/14/24 9/27/24 9/28/24 The Provider Order policy last revised 2/14/24 specially covered medications, the policy failed to include instructions for orders regarding additional care, treatments and services. In an interview on 10/2/24 at 10:14 AM, Staff C, Registered Nurse (RN) reported she followed up with Certified Nursing Assistants about failing to turn and reposition Resident #49 as ordered. When asked if staff are required to document Resident's #49 refusals to turn or reposition, Staff C replied, yes. Staff C reported Resident #49 often left the building for doctor ' s appointments, wound vac dressing changes and spent one to eight hours per day out with family. When asked if absences should be documented on the Repositioning Record, Staff C replied, yes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/3/24 at 10:05 AM, the Director of Nursing (DON) reported staff had room to improve compliance for repositioning orders and documentation. When asked about expectations regarding repositioning orders, the DON replied, Yes. The staff should reposition the resident and document it.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on clinical record review, staff interviews, and policy the facility failed to complete assessments as ordered by the physician for the necessary care and services. Clinical record review revealed the nursing staff failed to complete all required skin assessments for 1 out of 17 residents reviewed (Resident #49) and failed to follow physican orders for administration of oxygen for 1 of 1 resident reviewed, (Resident #6). The facility reported a census of 49 residents. Findings included: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #49 documented diagnosis of traumatic spinal cord dysfunction and an unhealed pressure ulcer. The MDS showed a BIMs score of 15, which indicated no cognitive impairment. The Care Plan for Resident #49 identified a risk for skin breakdown related to immobility due to a spinal cord injury. Conduct a systematic skin inspection daily. The Provider Order for Resident #49 dated 9/4/24 instructed staff to assess skin daily. The Skin Assessments Record for Resident #49 showed the facility failed to complete daily skin assessments during the look back period from 9/4/24 through 9/30/24: a. 9/5/24 b. 9/7/24 c. 9/8/24 d. 9/10/24 e. 9/11/24 f. 9/13/24 g. 9/14/24 h. 9/15/24 i. 9/17/24 j. 9/18/24 k. 9/19/24 l. 9/20/24 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	m. 9/21/24 n. 9/22/24 o. 9/24/24 p. 9/25/24 q. 9/26/24 r. 9/28/24 s. 9/29/24 The Skin Assessment Pressure Ulcer Prevention and Documentation Requirement identified in-services for nursing and other disciplines will be held as necessary and will include the following: a. Pressure ulcer protocols and guidelines b. Etiology and risk factors for skin breakdown c. Use of the Braden Scale for Predicting Pressure Sore Risk UDA d. Skin observation and assessment e. Selection and use of pressure redistribution devices f. Demonstration of positioning g. Instruction on accurate documentation In an interview on 10/3/24 at 10:05 AM, the Director of Nursing (DON) reported upon prior review of skin assessment documentation, the DON noted staff failed to complete skin assessments daily as ordered. The DON stated, I already followed up with the nurses. 26527 2. According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #6 scored 9 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident had diagnoses including coronary artery disease. The resident received oxygen (O2) therapy. The current Care Plan dated 3/4/21 identified the resident required oxygen therapy related to post covid complications. Interventions included administering oxygen per physician orders, may increase to 2-5 liters as needed to maintain saturations >90%, from 2 liters continuous. Written on the care plan date 8/19/24 the resident with O2 sat 82% on 2 liters. Increased to 3 liters per order, O2 sat 91%. The Director of Nursing (DON) signed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/2, O2 sat 88% on 2 liters, increased to 3 liters and O2 sat 92%, signed by the DON. On 9/30 O2 sat 89% on 2 liters, increased to 3 liters, O2 sat 96%, signed by the DON. On 9/30/24 at 2:22 p.m. the resident sat in her recliner with her eyes closed, oxygen on per nasal cannula at 3 liters. On 10/1/24 at 10 a.m. the resident slept in her recliner with her O2 set at 3L. A General Order with a start date of 3/5/21 showed the resident had an order for O2 at 2 liters continuous. The Medication Administration History for 8/1/24 to 8/31/24, 9/1/24 to 9/30/24, and 10/1/24 to 10/2/24 lacked the order or a place to initial the O2 administered. The Medication Administration History for 8/1/24 to 8/31/24, 9/1/24 to 9/30/24, and 10/1/24 to 10/2/24 included the order for Oxygen 2-5 liters as needed (PRN) to keep sats >90%. The medication record lacked any documentation the resident had her oxygen increased. The Progress Notes lacked documentation regarding the low O2 saturation on 8/19/24, 9/2/24, and 9/30/24, or assessment of the resident's vital signs and lung sounds. The O2 Sats for the resident documented O2 sats 8/5/24/ 8/12/24, 8/19/24, 9/2/24, 9/16/24, and 9/30/24. The sats page lacked followup O2 sats, even when the sats were documented low. The sats were only documented every 2 weeks since 8/19/24. Despite the Oxygen being at 2 liters each time the sats were low there was no documentation in the resident's clinical record of an assessment of the resident's respiratory status. The clinical record lacked documentation of how long the resident required increased oxygen, assessment after she had the oxygen decreased back down to 2 liters, and who monitored and made changes to the resident's O2. On 10/2/24 at 3:15 p.m. the DON stated the Certified Nursing Assistant's (CNA's) checked the O2 sats and documented. The resident's (O2 sats) should be checked 1x/week. She said they would need to address it. The facility policy Oxygen Administration, Safety, Mask Types dated 7/8/24 documented oxygen administration was carried out only with a medical provider order. A licensed nurse or other employee trained according to state regulations in the use of oxygen would be on duty and was responsible for the proper administration of oxygen to the resident. The procedure included assessing the resident for at least first 15 to 30 minutes after beginning of therapy and at regular intervals depending on the resident's condition.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 26527 Based on record review and staff interview, the facility failed to assure the physician evaluated for a dose reduction of a psychotropic medication for 1 of 5 residents reviewed (Resident #8). The facility reported a census of 49 residents. Findings include: Resident #8's Physician Order Report dated 9/3/22 to 10/3/24 documented the resident's diagnoses included Alzheimer's disease with late onset, dementia in other diseases classified elsewhere, moderate, with psychotic disturbance. With a start date of 11/20/2023, for Anti-Depressant Medication Use: observe resident closely for significant side effects (sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photosensitivity, excess weight gain), twice a day. The resident's medications included Amitriptyline 50 mg at bedtime with a start date of 11/20/23. A facility Antidepressant Drug Report dated 6/1/24 documented the resident received Amitriptyline 25 mg, 2 tabs at bedtime (hs) for Alzheimer's dementia with psychotic disturbance/visual hallucinations with a start date of 11/20/23. The resident had not had a dose reduction failure and due for a dose eval 5/2024. A Consultant Pharmacist Communication to the Physician dated 5/30/24 included: The resident had a current dose of Amitriptyline 50 mg at hs for dementia with behavioral symptoms. If tricyclic antidepressant (TCA) drugs were used to manage behavior, stabilize mood, or treat a psychiatric disorder, it was recommended they be reviewed for a possible gradual dose reduction (GDR) in an attempt to find the lowest effective dose. If a dose reduction was not possible at the time, please state the reasoning below, and the risk vs the benefit of continuing the drug at the current dose. The Physician response to the recommendation/finding, please check one of the following: Agree: Please write order(s). Other: (Please write a brief statement concerning the rationale for your response to the recommendation). The resident's clinical record lacked a response to a possible GDR. On 10/2/24 at 3:20 p.m. the Director of Nursing (DON) stated she couldn't speak to whether there was a GDR for the resident's Amitriptyline, she would have to look into it. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/24 at 11 a.m. during the exit conference with facility staff, the DON confirmed they did not have a response from the physician for evaluation of the resident's Amitriptyline for GDR.