STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	2027 College Avenue Elk Horn, IA 51531

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observations, electronic health record (EHR) review, document review, resident interviews, and staff interviews the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 2 of 5 resident reviewed (Resident #9 and #10). The facility reported a census of 52 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #9 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS indicated Resident #9 as frequently incontinent of urine and occasionally incontinent of bowel. On 5/14/24 at 1:52 PM Resident #9 stated she used her call light all the time and it was the only way she could get help. Resident #9 stated the staff frequently took longer than 15 minutes to respond to her call light. Resident #9 stated the staff needed more help. Resident #9 stated she turned the call light on that morning because she wanted to get out of bed. Resident #9 stated she waited and waited and waited and finally the staff came and got her out of bed. Resident #9 stated the response took way too long that morning. Resident #9 stated she knew how long the staff took to respond to the call light because she could read the clock and that the current time was 1:55 PM. Review of EHR revealed Resident #9 resided in room [ROOM NUMBER]. Review of document titled [NAME]-Care Report (call light log) dated 5/14/24 revealed on 5/14/24 at 6:03 AM room [ROOM NUMBER]'s call light was turned on. The response time on the call light in room [ROOM NUMBER] at 6:03 AM was 47 minutes and 59 seconds. Review of video footage with the Administrator for the hall with room [ROOM NUMBER] revealed from 6:00 AM - 6:30 AM on 5/14/24 no staff entered the room to answer the call light. Video footage review was only for a 30 minute duration. On 5/14/24 at 11:00 AM Staff A stated he did not feel there was enough nursing staff to care for the residents appropriately and the staff work short all the time. Staff A stated sometimes when staff call in, the staff is not replaced. Staff A stated that call lights did take longer than 15 minutes to be responded to at times. Staff A stated it happened that morning and room [ROOM NUMBER] was on longer than 15 minutes that morning. (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 11:00 AM Staff B stated she also did not feel there was enough nursing staff to care for the residents appropriately and the staff worked short all the time. Staff B stated sometimes when staff call in the staff is not replaced. Staff B stated that call lights did take longer than 15 minutes to be responded to at times and room [ROOM NUMBER] was on longer than 15 minutes that morning. 2. The MDS dated [DATE] for Resident #10 documented he scored 15 on the BIMS indicating intact cognition. The MDS documented the resident as dependent on staff for toileting hygiene and partial assist/moderate assist with toilet transfers. On 5/14/24 at 9:50 AM Resident #10 stated it seems like only agency staff are working because the staff are always different on the night and weekends. He stated he usually does not use his call light but when he does it will take longer than 15 minutes to answer the light on the evening and overnight shifts. He stated this has happened in the last month. Review of document titled [NAME]-Care Report (call light log) dated 5/14/24 revealed on 5/9/24 at 4:56 PM room [ROOM NUMBER]'s call light was turned on. The response time on the call light in room [ROOM NUMBER] was 21 minutes and 7 seconds. Review of policy titled, Call Light - R/S, LTC, Therapy and Rehab with revised 8/1/23 documented the purpose was to promptly answer the residents call light and to respond to the residents request as soon as possible. On 5/14/24 at 11:15 AM the Administrator stated the facility did have a call light report that could be run. The Administrator stated when reviewing over the last month she had noticed call lights lasting longer than 15 minutes a couple of times. The Administrator stated the facility's expectation was that the call light will be answered within 15 minutes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observations, clinical record review, policy review, and staff interviews the facility failed to provide appropriate infection prevention practices when completing blood sugar monitoring for 3 of 3 residents reviewed (Resident #4, #5, and #6). The facility reported a census of 52 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15 indicating moderate cognitive impairment. The MDS documented Resident #4 had a diagnosis of type 2 diabetes Mellitus. Review of Resident #4's Clinical Physician Orders documented an order dated 10/10/23 for blood glucose monitoring 4 times a day. On 5/14/24 at 11:30 AM observed Resident #4 being pushed down the hall by Staff C into an unoccupied room. Staff C returned to the medication cart to retrieve the blood glucose machine and supplies. Staff C applied gloves without completing hand hygiene. Staff C entered the room and cleansed Resident #4's right hand index finger with an alcohol wipe. Staff C returned to the medication cart, obtained keys from her pocket, unlocked the medication cart, wrapped blood glucose machine in cleansing wipe, removed insulin from medication cart and drew up insulin. Staff C locked the medication cart, entered Resident #4's room, and administered insulin in Resident #4's right upper arm. Staff C returned to the medication cart, put medication away and charted on the computer. Staff C removed her gloves. Staff C locked the medication cart, returned to Resident #4, and pushed Resident #4 in a wheelchair back to the therapy department. Staff C returned to the medication cart and pushed the medication cart down the hall to another resident's room. Staff C removed medication and began to administer this resident's medication without hand hygiene. 2. The MDS dated [DATE] documented Resident #5 had a BIMS score of 15 indicating moderate cognitive impairment. The MDS documented Resident #5 had a diagnosis of type 2 diabetes Mellitus. Review of Resident #5's Clinical Physician Orders documented an order dated 2/29/24 for blood glucose monitoring before meals and at bedtime. On 5/14/24 at 11:41 AM observed Staff D remove the blood glucose machine from the medication cart and apply gloves without hand hygiene. Staff D knocked on the door for Resident #5 and entered the room. Staff D cleansed Resident #5's ring finger on his left hand and utilized the lancet to obtain a blood sample. Staff D used a cotton ball to remove the 1st drop of blood. Staff D left the room, returned to the medication cart, removed gloves completed hand hygiene. 3. The MDS dated [DATE] documented Resident #6 had a BIMS score of 15 indicating moderate cognitive impairment. The MDS documented Resident #6 had a diagnosis of type 2 diabetes Mellitus. Review of Resident #6's Clinical Physician Orders documented an order dated 4/9/22 for blood glucose monitoring before meals and at bedtime. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 11:21 AM observed Staff C remove the blood glucose machine from the medication cart and apply gloves. Staff C did not complete hand hygiene. Staff C entered Resident #6's room. Staff C dropped the lancet on the ground in Resident #6's room, picked the lancet up off the ground and continued to use it. Staff C cleansed Resident #6's ring finger on her right hand with an alcohol wipe. Staff C returned to the medication cart in the hallway. Staff C obtained the insulin and a syringe from a medication cart and administered the insulin. Staff C returned to the medication cart and charted on the computer. Staff C removed gloves and completed hand hygiene. Review of policy titled, Hand Hygiene revised 3/29/22 revealed hand hygiene would be completed when entering a resident's room, prior to clean task, after bodily fluid/glove removal, exiting room, before preparing or administering medication, before donning gloves, and after removing gloves regardless of task completed. On 5/16/24 at 2:45 PM the Administrator stated the facility's expectation was that hand hygiene would have been completed prior to and after entering a resident's room, also prior to any medication administration. The Administrator stated hand hygiene would be completed when gloves were removed, and hand hygiene would be completed after leaving the room.