STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165432	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Living Senior Campus	2421 Lutheran Drive Muscatine, IA 52761

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 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** 26529 Based on clinical record review, personnel records, medical examiner interview and staff interviews, the facility failed to provide adequate staff and supervision to assist a resident who called out for help in a timely manner for 1 of 5 residents (Resident #1) reviewed for safety. Per staff interview, Resident #1 called out for help on [DATE] at approximately 4:30 AM, and staff were unable to respond for up to 10 minutes. The resident subsequently found face down in bed, feet on the floor, unresponsive. The facility reported a census of 129 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) on [DATE] at 5:35 p.m. The IJ began on February 11, 2024, when Resident #1 found unresponsive. Facility staff removed the Immediate Jeopardy on [DATE] through the following actions: a. The Director of Nursing (DON) or designee will educate On-Call Clinical Staff on responsiveness to staffing calls. b. The DON or designee will educate direct care Licensed Nurses prior to working their next shift on escalation of unanswered attempts related to staffing to contact on call Nurse. c. Labor meeting daily Monday through Friday to review previous days staffing requirements and anticipate staffing needs with Executive Director, DON, Staffing Coordinator and other applicable staff. d. Resident interviews (10) regarding satisfaction with staffing ratios will be conducted by the Executive Director or designee weekly. e. Staff interviews (10) regarding satisfaction with staffing ratios will be conducted by the Executive Director or designee weekly. f. Nursing staff will be educated on responding to resident ' s needs prior to working next shift. (Calling out for assistance). The scope lowered from J to G at the time of the survey after ensuring the facility implemented education and their policy and procedure. Findings include: (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 diagnoses included: arthritis, osteoporosis, Alzheimer's disease, anxiety, and depression. A score of 3 out of 15 on the Brief Interview for Mental Status (BIMS) indicated a severe cognitive impairment. The assessment revealed Resident #1 required substantial/maximal assistance (meaning staff provided more than half of the effort to complete a task) for transfers to and from bed and chair, and to roll from lying on back to left and right side, and to return to lying on back on the bed. The MDS assesses Resident #1 as having clear speech with distinct intelligible words, and sometimes understood, and usually understood others. The Care Plan, created on [DATE], and initiated on [DATE], included a Focus Area for Safety and Falls R/T (related to) current medical and physical status. Poor safety awareness r/t dementia. Interventions included: 1. Body pillow to be placed when I am in bed, initiated [DATE]. 2. Med [NAME] (similar to a mattress) placed next to my bed, initiated on [DATE]. 3. Staff education to ensure placement of medmizer when in bed, initiated on [DATE]. 4. Bed in low position, no initiation date indicated. 5. Call light positioned for easy access, no initiation date indicated 6. Check for unmet needs: pain, toileting, hunger, thirst, temperature, no initiation date indicated A Care Plan Focus Area, initiated on [DATE], for ADL (Activities of Daily Living) Complications with Deficit's with ADL R/T current medical and physical status. Has meds and dx (diagnosis) that can affect ADL's. I have decreased mobility and depend on others to assist me with ADL's. Interventions included Bed Mobility x1 (one staff) extensive assist. I am not consistent with being able to turn side to side. I am dependent with laying to sitting. A Nursing Progress Note transcribed on [DATE] at 4:56 AM. by Staff K, Licensed Practical Nurse (LPN) stated: Resident was found by CNA (Certified Nursing Assistant) at 4:35 a.m. on the mat unresponsive. CNA notified Staff L, LPN about resident. No vitals noted. This nurse and Staff L verified resident's death at 4:35 a. m. This nurse called 911 to notify and speak with the Medical Examiner (ME) about resident. Waiting call back. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 7:41 AM, Staff H, Certified Nursing Assistant (CNA) stated she worked the night shift on [DATE], assigned to the 600 Hall. She stated she worked on a different hall then where Resident #1 resided. Staff H stated when Staff M, CNA left at 2:00 AM she also covered the 500 hall. She stated while on the 600 Hall, on her way to the 500 Hall around 4:30 AM heard the resident [Resident #1] yell out but didn't think it was anything serious. Staff H stated she headed into a different room a few doors down to provide care and answer the call light. While in this room, Staff I, CNA, came in the room and said Resident #1 was crying. Staff H stated it was about 5 to 10 minutes before they went to Resident #1's room and found her face down, the front part of her lower part of her body was on the fall mattress next to the bed, and the upper part of her body was on the upper part of the bed, chest down with her head face down, between the mattress and the side rail attached to the bed, the bed was in low position, and she was certain that was how the resident was positioned. Staff H stated she thought the resident must have reached for something and how she ended up on her stomach, and thought the resident yelled because her head was stuck there and she couldn't get up. The resident was pale, she didn't think she was breathing and sent Staff I to get the nurse. Staff L, LPN came to the room and directed them to turn the resident over, put her on the fall mattress and to get Staff K, LPN as that was the nurse assigned to the resident. When Staff K got to the room, the resident was on her back on the fall mattress. Staff H reported she had last seen the resident about an hour and a half prior, when provided incontinence care to the resident. At that time, the resident was in her bed, she thought positioned on her side and covered with a blanket. During an interview on [DATE] at 12:57 PM, Staff I, CNA, stated she worked the night shift on [DATE] on the 700 Hall. She stated another staff had left, and she was told by a nurse to cover both halls (assigned 700 Hall, and pick up 600 Hall). Staff I stated she told the nurse she couldn't cover both halls and they came to some sort of agreement to split one of the halls. She needed help for rounds, tried to find Staff H, CNA and as she looked for her saw the resident had slid partway out of the bed and onto a fall mat, her upper body was on the bed and her head was face down. The resident wasn't saying anything. Staff I stated she went to find Staff H, but found Staff L, LPN. Staff I stated Staff L told her it wasn't her hall and she needed to find Staff H. She found Staff H in another room and they went into Resident #1 room together, it didn't look like the resident was breathing so she went to get the nurse (Staff L). Staff L came, said to flip the resident over, they lifted the resident onto the fall mat on the floor and laid her on her back. Then she had to go to the locked unit so Staff K, the other nurse [LPN], could come over, Staff K was in the CCDI Unit because that CNA had also left in the middle of the shift that night. During an interview on [DATE] at 8:18 AM, Staff K, LPN, stated she worked the night shift on [DATE]. She stated she was in the CCDI unit when a CNA got her, told her the resident [Resident #1] had passed and Staff L needed help. When she got to the resident's room the resident was on the fall mattress positioned on her back, they had already moved her. Staff L said the resident was face down when they found her and turned her over, and they both confirmed the resident's death at that time. Staff K called 911 to notify the Medical Examiner (ME), and spoke to the ME when he came to the facility that morning. Staff K stated they were too short staffed that night, the aides that were there had to cover multiple halls so she called the manager on call, Staff S, Assistant Director of Nursing (ADON), to report they were very short staffed and needed help, Staff S refused to come to the facility and directed her to figure it out. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 4:29 PM, Staff L, LPN, stated she worked on the night shift on [DATE], and couldn't recall the details associated to the resident's death. She stated one of the CNA's came to her for help, the resident [Resident #1] was on the fall mattress and the bed, they had to turn her so she could assess her, but the other nurse, Staff K, had the resident that night, she came and took over, called the ME, notified family and charted it all, and really didn't remember much about it. During another interview on [DATE] at 9:24 AM, Staff L stated she remembered more about the night of [DATE]. She stated one of the aides came and told her the resident [Resident #1] was on a mat and a low bed, she [Staff L] told her it wasn't a fall because they were the same height and directed her to get the other aide to help her get the resident back in bed. Then both aides came and said she needed to come. Staff L stated when she got to the room the resident was face down on the bed, her lower body on the fall mat and her chest was sort of leaned onto the bed. Staff L turned her over onto her back, onto the mat, the resident wasn't breathing. Staff K arrived, and she told Staff K she was face down, and Staff K took over from there and why Staff K charted it. During an interview on [DATE] at 1:51 PM, Staff J, CNA, stated she worked at the facility through agency, a lot of double shifts and cared for the resident several times. On the night of [DATE] she was assigned to a different hall with the nurse, Staff L, and was there when Staff L came back from the resident's room, said the resident was found dead, face down. Staff J stated they were very short staffed that night. She stated she had taken care of the resident the day before and there were no concerns during the shift. During an interview on [DATE] at 9:11 AM, Staff M, CNA, stated she was scheduled to work the night shift on [DATE]. Staff M stated she told the Staff R, Scheduler that she couldn't work due to a family situation, but Staff R begged her to work until 2 a.m., and she agreed. Staff M thought there would be a someone scheduled to relieve her at 2:00 AM, but there was not. Staff M stated she reported off to one of the other aides from another hall before she left. Staff M reported she had last seen the resident [Resident #1] around 12:30 a.m. to check and change her, the resident was in her bed and okay at that time. She stated Staff K, LPN had just been in the room and administered medication to the resident. During an interview on [DATE] at 11:06 AM, Staff O, CNA, stated she had worked on all of the resident halls at the facility, usually on the night shift. When they are short staffed the CNA's have to take two halls, they can't hear call lights from the other Nurse's Station for the other hall they are also assigned to. On the night of [DATE] she was assigned to the CCDI Unit, by herself. She had a medical emergency that night and had to go to the emergency room , she thought it was around 3:30 AM. Staff K, LPN had to relieve her because they were so short staffed, the aides were already doubled up on halls that night. During an interview on [DATE] at 12:41 PM, the Investigator from the Medical Examiner office stated he went to the facility on the night of the residents death on [DATE]. He stated the resident was on her back, on a mattress on the floor, with a pillow under her head. The resident was dressed in a blue shirt and covered with a blanket. The Investigator stated staff reported to him the resident was found dead, and did not tell him she was found face down or had been moved. The payroll report and staff interview indicated night shift that started at 10 PM on [DATE] and ended at 6 a. m. on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Daily Night Shift Staffing Assignment Sheet for the 10 p.m. on [DATE] to 6 a.m. on [DATE] night shift revealed: Staff L, LPN, assigned to the 300, 600 and 700 Halls. Staff K, LPN, assigned to the 400 and 500 Halls, and the facility's locked CCDI Unit (Chronic Confusing or Dementing Illness). Staff J, CNA (Certified Nursing Assistant) assigned to the 300 Hall Staff P, CNA assigned to the 400 Hall. Staff M, CNA assigned to the 500 hall with notation went home at 2 a.m. Staff H, CNA assigned to the 600 Hall, with notation went to 500 at 2 a.m. Staff I, CNA, assigned to the 700 Hall, with notation covered 7 and 6 at 2 a.m. Staff O, CNA, assigned to the CCDI Unit. A payroll report for the staff that worked on the night shift on that night revealed Staff M clocked out at 1:57 AM, Staff O clocked out at 3:48 AM, with additional clock ins indicated for the shift. During an interview on [DATE] at 6:29 PM, with the DON and Staff S, ADON, and informed that Staff O clocked out at 3:48 a.m. on [DATE], the DON stated Staff O was a smoker, she probably clocked out for her break and forgot to clock in when she came back. When informed that Staff K reported she contacted Staff S on the [DATE] to [DATE] night shift with requests for assistance due to short staffing, the DON stated there was no proof that Staff K called for assistance, then Staff S stated they called her to notify her of the resident's death, but never asked for assistance. A Written Reprimand in Staff S's personnel file dated [DATE] stated on [DATE] - [DATE] the employee was called two times with concerns over lack of staff on the night shift. Staff S directed the CNA's to split hallways. The immediate supervisor had directed multiple times that the CNA's were not to split halls on the night shift. The employee failed to fulfill their on-call responsibilities and this potentially puts resident care at risk.