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	08/07/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, family and staff interviews, and policy review, the facility failed to conduct quarterly Care Conferences (CC) for 1 of 3 residents reviewed (#4). The facility reported a census of 124 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #4 dated 3/26/25 did not include a Brief Interview for Mental Status (BIMS) score; however, an MDS assessment dated [DATE] revealed a BIMS score of 06 out of 15, which indicated severely impaired cognition. The MDS dated [DATE] included diagnoses of coronary artery disease (CAD), congestive heart failure (CHF), Alzheimer's Disease, non-Alzheimer's dementia, venous insufficiency, and seborrheic dermatitis (a common skin condition that causes a scaly, flaky, itchy rash, often on the scalp, face, and body folds). The Care Plan dated 2/24/23 indicated the resident had potential for complications with impaired skin integrity including skin tears, bruising AND/OR pressure related to current medical and physical status and had lower extremity (LE) edema. There were four (4) modifications made to the Care Plan's skin integrity focus.During an interview on8/04/25 at 12:27 PM, a family member stated Care Conferences were never completed.On 8/05/25 at 5:12 PM, Staff D, Social Services designee (SS) stated Care Conferences (CC) are scheduled 1 -2 weeks after MDS assessments are completed quarterly to ensure the resident's information is current. She also stated the resident and resident's representative are notified by mail and are contacted the day before the scheduled Care Conference if no confirmation is received. She added she has been the SS designee since 5/07/25 and documents CC in the resident's electronic health record (EHR) so she was not aware if previous CC summaries were stored on paper. The EHR indicated MDS assessments were completed 7/23/24, 10/15/24, 12/27/24, 3/26/25, and 6/17/25. The Assessments tab revealed Care Conference Summaries were documented on 7/31/24 and 6/17/25. There were no documented summaries for 10/24, 12/24, or 3/25.During an interview on 8/07/25 at 12:21 PM, the Director of Nursing (DON) stated a Care Plan conference should have occurred every quarter or upon a change of condition.A policy titled Care Plan - Reviews/Conferences reviewed 8/07/25 indicated the community will conduct a care plan review/conference at least quarterly, and as needed, that is interdisciplinary, provides an in-depth review of the resident's plan of care, and provides an opportunity for resident and resident representative and/or family discussion/input.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, family and staff interviews, and policy review, the facility failed to provide timely physician and family notification for 1 of 3 residents (Resident #4) who experienced a newly documented open wound. The facility reported a census of 124 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #4 dated 3/26/25 did not include a Brief Interview for Mental Status (BIMS) score; however, an MDS assessment dated [DATE] revealed a BIMS score of 06 out of 15, which indicated severely impaired cognition. The MDS dated [DATE] included diagnoses of coronary artery disease (CAD), congestive heart failure (CHF), Alzheimer's Disease, non-Alzheimer's dementia, venous insufficiency, and seborrheic dermatitis (a common skin condition that causes a scaly, flaky, itchy rash, often on the scalp, face, and body folds). It also revealed the resident was independent with rolling left-to-right, sit-to-lying, and lying-to-sitting on the side of the bed, and required supervision with all other mobility. It further revealed, based on clinical assessment, the resident did not have any unhealed pressure ulcers or injuries and did not have any venous or arterial ulcers. It indicated the resident received dressings to his legs and feet.The Care Plan dated 8/29/23 indicated the resident had potential for complications with impaired skin integrity including skin tears, bruising AND/OR pressure related to current medical and physical status and had lower extremity (LE) edema. It directed staff to observe skin with AM/PM cares and with toileting for redness, rashes, open areas, pain, swelling and report them to team leader and review skin concerns with medical doctor (MD).The electronic health record (EHR) included the following physician's order dated 2/06/24: Skin Management: Weekly Body Observation and Form to be completed 1x Week. Open Weekly Skin Check Tool in assessments and complete every evening shift every Tuesday for Prevention. If impairments present, measure and document a skin/wound progress note. Another physician's order dated 10/15/24 directed staff to notify provider if any increase in swelling, scratching or new lesions.A Physician Progress Note dated 4/14/25 indicated an increase in the resident's LEs (lower extremities) and included an order to increase the resident's furosemide (diuretic - medication that increases urination to remove excess water) to 60 milligrams (mg) by mouth twice daily.The Weekly Skin assessment dated [DATE] included additional information of redness to bilateral lower extremities (BLE), left shin has small open area approximately 1.5 in in length x 0.5 in width. Treatments as ordered. It did not include documented MD or family notification.The Weekly Skin Assessment Question History did not include previously measured BLE open areas.Review of the Nurse Progress Notes for 4/15/25 did not include MD (medical doctor) or family notification for the new BLE open area.On 8/06/25 at 12:33 PM, Staff C, Licensed Practical Nurse (LPN) stated the MD, family, and Assistant Director of Nursing (ADON) or Administrator On-Call (AOC) should be notified of newly identified resident skin wounds and notifications are documented in the Nurse Progress Notes. She also stated she didn't recall whether or not she contacted the MD or resident's family.On 8/07/25 at 12:21 PM, the Director of Nursing (DON) stated staff should have called the family and physician. They should have initiated any standing orders and continued attempts to contact the physician and document the call.A policy titled Notification of Change reviewed 8/07/25 indicated the community will consult the resident's physician, nurse practitioner, or physician assistant and notify the resident representative or an interested family member when there is:a. An accident (including falls) which results in injury and has the potential for requiring physician-intervention.b. Acute illness or a significant change in the resident's physical, mental, or psychosocial status (i.e., deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).c. A need to alter treatment significantly (i.e. a need to discontinue or change an existing form of treatment due to adverse consequences or to commence a new form of treatment).d. A decision to transfer of discharge the resident from the community.e. A change in resident rights.f. Changes in skin integrity, abnormal labs, changes in cognition, signs/symptoms of infection/virus, etc.any change that would constitute the need to alter the resident's orders and care for the resident.

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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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, long term care ombudsman interview, and staff interview, the facility failed to cite the correct chapter of the Iowa Legislature State Regulations when issuing an involuntary discharge notice to 1 of 1 residents (Resident #1) reviewed. The facility reported a census of 124 residents.Findings include:The Minimum Data Set (MDS) of Resident #1 dated 6/4/25 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS recorded the resident experienced mood symptoms of feeling down, depressed, or hopeless on one day of the lookback period. The MDS recorded the resident dependent upon staff assistance for chair/bed-to-chair transfers. The MDS documented diagnoses that included: paraplegia, anxiety, depression, and alcohol abuse with alcohol-induced mood disorder.On 6/30/25, the facility addressed and hand delivered an involuntary discharge notice to Resident #1. The document, dated 6/30/25, titled Emergency Notice of Involuntary Discharge referenced Iowa Administrative Code 481-57.14(2) as state rule and regulation governing involuntary transfer. The document advised Resident #1 of being discharged to an appropriate facility or placement that can meet his needs and that he was being discharged due to his behavior posing a threat to the health and safety of other residents. During an interview on 7/31/25, the Long-Term Care Ombudsman stated the facility cited the wrong Iowa Administrative Code on the discharge notice. The LTCO stated Chapter 57 documented on the notice applies to Resident Care Facilities. The LTCO explained the facility should have referenced Chapter 58 for Long Term Care Facilities. She stated this error would normally have made the notice not be applicable and it should have been rewritten and the discharge process started over when this was completed. She added she was out of town during the proceedings, and when Resident #1 appealed the decision, the Administrative Law Judge upheld the discharge due to the facility having substantially complied with the notice requirement and the resident did not argue with the manner of the notice. During an interview on 8/6/25 the Administrator stated he had corrected the verbiage to Chapter 58 for any future involuntary discharges.

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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 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** Based on clinical record review, family and staff interviews, the facility failed to provide timely interventions for 1 of 3 residents who experienced a newly documented open wound (#4). The facility reported a census of 124 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #4 dated 3/26/25 did not include a Brief Interview for Mental Status (BIMS) score; however, an MDS assessment dated [DATE] revealed a BIMS score of 06 out of 15, which indicated severely impaired cognition. The MDS dated [DATE] included diagnoses of coronary artery disease (CAD), congestive heart failure (CHF), Alzheimer's Disease, non-Alzheimer's dementia, venous insufficiency, and seborrheic dermatitis (a common skin condition that causes a scaly, flaky, itchy rash, often on the scalp, face, and body folds). It also revealed the resident was independent with rolling left-to-right, sit-to-lying, and lying-to-sitting on the side of the bed, and required supervision with all other mobility. It further revealed, based on clinical assessment, the resident did not have any unhealed pressure ulcers or injuries and did not have any venous or arterial ulcers. It indicated the resident received dressings to his legs and feet.The Care Plan dated 8/29/23 indicated the resident had potential for complications with impaired skin integrity including skin tears, bruising AND/OR pressure related to current medical and physical status and had lower extremity (LE) edema. It directed staff to observe skin with AM/PM cares and with toileting for redness, rashes, open areas, pain, swelling and report them to team leader and review skin concerns with medical doctor (MD).The electronic health record (EHR) included a physician's order dated 10/15/24 that directed staff to notify provider if any increase in swelling, scratching or new lesions.The Weekly Skin assessment dated [DATE] included a redness to bilateral lower extremities (BLE), left shin has small open area approximately 1.5 in in length x 0.5 in width that was not previously identified. Treatments as ordered. The assessment tool lacked a documented intervention.The Nurse Progress Notes for 4/15/25 did not include a documented intervention for the new BLE open area.On 8/06/25 at 12:33 PM, Staff C, Licensed Practical Nurse (LPN) stated the MD, family, and Assistant Director of Nursing (ADON) or Administrator On-Call (AOC) should be notified of newly identified resident skin wounds and get orders from the doctor. She also stated she didn't recall whether or not she contacted the MD or resident's family.On 8/07/25 at 12:21 PM, the Director of Nursing (DON) stated staff should have called the physician, gotten an order, started the order, documented it, and notified the family of the new order.In an email dated 8/07/25 at 1:24 PM, the Administrator indicated the facility follows the nursing standards of practice related to assessments.

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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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility self report, State of Iowa Administrative Hearings Findings, and staff interviews, the facility failed to perform behavioral health assessments for Resident #1 after he was served a 30 day involuntary discharge notice following an alleged assault on another resident. Resident #1 had a documented history of major depressive disorder and suicidal ideation and was placed on one to one (1:1) supervision after the alleged assault. On [DATE] the 1:1 supervision was discontinued to address a staffing shortage without Resident #1 being assessed. During the early morning hours of [DATE], with no 1:1 supervision, Resident #1 used items within reach and committed suicide hours before his scheduled discharge from the facility. The facility reported a census of 124 residents. On [DATE] at 5:00 pm, the State Survey Agency informed the facility of the failure to perform behavioral health assessments following notification of an involuntary discharge created an Immediate Jeopardy situation, which resulted in the suicide of a resident. The Immediate Jeopardy began on [DATE]. The facility removed the immediacy on [DATE] at 12:00 pm when the facility staff implemented the following Corrective Actions: Audits of all residents for Psychosocial History compliance Audits of all residents for a history of suicidal ideation or attemptsCreation and Implementation of a Suicide Prevention PolicyCreation and Implementation of a Phone Answering PolicyEducation to all employees of Suicide in Older AdultsEducation to all employees of Recognizing Behavioral Symptoms in Residents at Risk for Self HarmEducation to all employees for Clinical Procedure for Care of Residents with Depression and Assessing and Screening for Suicide RiskEducation to all employees of Resident RightsAudits of all residents behavior documentation for suicidal ideationsDiagnosis report for impulsivenessEducation to managerial staff of Behavior Interventions may only be changed/modified/discontinued by the Executive Director or the Director of NursingThe scope and severity lowered from a J to a G (harm that is not immediate) at the time of the survey after ensuring the facility implemented their policy andprocedures, audits, and staff education.Findings include:The Minimum Data Set (MDS) of Resident #1 dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS recorded the resident experienced mood symptoms of feeling down, depressed, or hopeless on one day of the lookback period. The MDS recorded the resident dependent upon staff assistance for chair/bed-to-chair transfers. The MDS documented diagnoses that included: paraplegia, anxiety, depression, and alcohol abuse with alcohol-induced mood disorder. The Care Plan of Resident #1 identified a Focus Area of Mood Behavior, stating Resident #1 had a diagnosis of Major Depressive Disorder. It directed staff to perform BIMS and PHQ-9 (an assessment used to screen for and measure the severity of depression) upon admission, quarterly, annually and as needed and to notify the physician as needed with concerns. The Care Plan additionally directed staff to keep the resident's routine the same as much as able and to offer opportunities for the resident to express feelings. The Care Plan additionally directed for social services to intervene as needed. The Care Plan identified an additional Focus Area of Abuse Vulnerability, history of suicide attempts. The Care Plan directed Staff to observe and provide a safe environment, staff to receive annual training and for Notifications to be made to Immediate Supervisor. The Facility Reported Incident (FRI) dated [DATE] documented that, on [DATE], Resident #3 reported to the facility chaplain that she had been physically assaulted by Resident #1 on [DATE]. According to the FRI, Resident #1 had grabbed and squeezed the upper leg of Resident #3 while he was passing by her in his electric wheelchair. The facility immediately ensured separation of the two residents, assigning a 1:1 Certified Nursing Assistant (CNA) to supervise Resident #1 to maintain that separation. A skin assessment of Resident #3 revealed black and blue bruises consistent with her account of the incident. The Sheriff's Office was contacted and a police report was filed. In a discussion between Resident #1 and the Administrator, Resident #1 displayed an unprompted awareness of the identity of Resident #1. The facility initiated an emergency discharge of Resident #1, and an Emergency Notice of Involuntary Discharge was hand delivered to Resident #1 on [DATE]. With the assistance of the facility's Social Services Director, Resident #1 filed an appeal to the discharge and a hearing took place on [DATE]. On [DATE], the Director of Nursing (DON) stated that she and the Administrator together notified Resident #1 on [DATE] that the discharge had been upheld in the hearing and offered him assistance to file a second appeal. She stated Resident #1 declined her assistance, stating he was resigned to it that he was discharging, and asked for some boxes to pack his belongings. She stated he also requested the facility continue to work on finding alternate

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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 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. (continued on next page)

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F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility self report, State of Iowa Administrative Hearings Findings, staff and family interviews, and facility policy review, the facility failed to recognize and address potential statements and behaviors that indicated Resident #1's self harm risk after he was served a 30 day involuntary discharge notice following an alleged assault on another resident. Resident #1 had a documented history of major depressive disorder and suicidal ideation and was placed on one to one (1:1) supervision after the alleged assault. In the days leading up to his discharge, multiple staff members stated they observed Resident #1's potential signs of worsening depression or heard him verbalize comments of potential self-harm but did not report these concerns to facility management. During the early morning hours of [DATE], without 1:1 supervision in place, Resident #1 used items within reach and committed suicide hours before his scheduled discharge from the facility. The facility reported a census of 124 residents. On [DATE] at 5:00 pm, the State Survey Agency informed the facility the staff failure to recognize, address and report potential statements and behaviors of self-harm following the notification of an involuntary discharge created an Immediate Jeopardy situation, which resulted in the suicide of a resident. The Immediate Jeopardy began on [DATE] The facility removed the immediacy on [DATE] at 12:00 pm when the facility staff implemented the following Corrective Actions: Audits of all residents for Psychosocial History compliance Audits of all residents for a history of suicidal ideation or attemptsCreation and Implementation of a Suicide Prevention PolicyCreation and Implementation of a Phone Answering PolicyEducation to all employees of Suicide in Older AdultsEducation to all employees of Recognizing Behavioral Symptoms in Residents at Risk for Self HarmEducation to all employees for Clinical Procedure for Care of Residents with Depression and Assessing and Screening for Suicide RiskEducation to all employees of Resident RightsAudits of all residents behavior documentation for suicidal ideationsDiagnosis report for impulsivenessEducation to managerial staff of Behavior Interventions may only be changed/modified/discontinued by the Executive Director or the Director of NursingThe scope and severity lowered from a J to a G (harm that is not immediate) at the time of the survey after ensuring the facility implemented their policy and procedures, audits, and staff education. Findings include:The Minimum Data Set (MDS) of Resident #1 dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS recorded the resident experienced mood symptoms of feeling down, depressed, or hopeless on one day of the lookback period. The MDS recorded the resident dependent upon staff assistance for chair/bed-to-chair transfers. The MDS documented diagnoses that included: paraplegia, anxiety, depression, and alcohol abuse with alcohol-induced mood disorder. The Care Plan of Resident #1 identified a Focus Area of Mood Behavior, stating Resident #1 had a diagnosis of Major Depressive Disorder. It directed staff to perform BIMS and PHQ-9 (an assessment used to screen for and measure the severity of depression) upon admission, quarterly, annually and as needed and to notify the physician as needed with concerns. The Care Plan additionally directed staff to keep the resident's routine the same as much as able and to offer opportunities for the resident to express feelings. The Care Plan additionally directed for social services to intervene as needed. The Care Plan identified an additional Focus Area of Abuse Vulnerability, history of suicide attempts. The Care Plan directed Staff to observe and provide a safe environment, staff to receive annual training and for Notifications to be made to Immediate Supervisor. The Facility Reported Incident (FRI) dated [DATE] documented that, on [DATE], Resident #3 reported to the facility chaplain that she had been physically assaulted by Resident #1 on [DATE]. According to the FRI, Resident #1 had grabbed and squeezed the upper leg of Resident #3 while he was passing by her in his electric wheelchair. The facility immediately ensured separation of the two residents, assigning a 1:1 Certified Nursing Assistant (CNA) to supervise Resident #1 to maintain that separation. A skin assessment of Resident #3 revealed black and blue bruises consistent with her account of the incident. The Sheriff's Office was contacted and a police report was filed. In a discussion between Resident #1 and the Administrator, Resident #1 displayed an unprompted awareness of the identity of Resident #1. The facility initiated an emergency discharge of Resident #1, and an Emergency Notice of Involuntary Discharge was hand delivered to Resident #1 on [DATE]. With the assistance of the facility's Social Services Director, Resident #1 filed an appeal to the discharge and a hearing took place on [DATE]. On [DATE], the Director of Nursing (DON) stated that she and the Administrator together notified Resident #1 on [DATE] that the discharge had been upheld in the