

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Lutheran Living Senior Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336</p> <p>Based on record review, interviews, and the facility policy, the facility failed to report an alleged abuse incident for 1 of 1 residents reviewed for abuse (Resident #52). The facility reported a census of 124 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 scored an 8 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition moderately impaired. The MDS revealed the resident required partial/moderate assistance with toileting hygiene, upper and lower body dressing; sit to lying; lying to sitting; sit to standing; chair/bed to chair transfer; and toilet transfer. The MDS revealed the resident frequently incontinent of urine and occasionally incontinent of bowel. The MDS revealed medical diagnoses of anxiety disorder and depression.</p> <p>The Care Plan revealed a focus area dated 4/15/19 for risk of side effects of psychotropic medications related to anxiolytic and antidepressant medication therapy. Resident had a diagnosis of major depressive disorder and anxiety disorder and can become tearful at times. Resident had a history of making false statements. The interventions dated 4/15/19 revealed allowing resident to talk about her feelings, or cry/vent.</p> <p>The EMR (Electronic Medical Record) revealed the following Medical Diagnoses:</p> <ul style="list-style-type: none"> a. unspecified intellectual disabilities b. anxiety disorder, unspecified c. other symptoms and signs involving cognitive functions and awareness d. major depressive disorder, single episode, full remission e. nocturnal enuresis <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Incident Progress Note (late entry) dated 12/6/24 at 7:56 AM, revealed this writer was notified via phone by 3rd shift nurse that was on 600 hall of incident, she stated the following: The resident had propelled herself in her WC (wheelchair) to the [skilled unit] side of the building, the CNA (Certified Nurse Aide) over in [skilled unit] reported that Resident #52 was crying and when she asked Resident #52 what was wrong , Resident #52 stated that colored girl made me get up, she hit me and called me a B****. The CNA then told her nurse and the both of them took Resident #52 to their dining room, got her a hot chocolate and a snack to try and calm Resident #52 down. During this time Resident #52 was c/o (complains) her pants being too tight, so the [skilled unit] CNA went to Resident #52 room on 600 hall to get her a more comfortable pair of pants,while over there she told the 600 hall nurse what was going on, she then brought the pants to [skilled unit] and took Resident #52 to the bathroom, helped her change her pants, While assisting the resident in changing her pants she looked over the residents skin/body (as she was instructed to by her nurse) to check for any areas of concern, no areas of concern were noted. [skilled unit] CNA then took her back to the dining room to finish her snack and [NAME]. 600 hall nurse told this writer she had questioned the accused CNA about the situation the CNA [name redacted] stated the following: when she was trying to get the resident the resident wasn't happy about getting up but she needed to d/t (due to) her bedding being completely saturated with urine. She got her cleaned up and put in WC, did the residents hair in a ponytail, gave the resident her glasses and then the resident proceeded down the hall, the resident was not crying at that time.</p> <p>This writer was the nurse on call at the time, I called the DON (Director of Nursing) and Administrator right after I was informed and the DON instructed me to go to the facility and investigate the situation. I did, I got statements from everyone who talk/interacted with the resident that night/morning. I also did a head-to-toe assessment on the resident when I got to the facility, no areas of concern were seen. I then called the administrator and went over all information I had gathered from my investigation. We decided to implement the following as precaution, the accused CNA will no longer be assigned to 600 hall, and I will instruct staff to do cares for this resident in pairs just as precaution. After informing the residents sister of the situation, she requested Resident #52 not be on the 3rd shift get up list, I will take her off that list. The resident's sister [name redacted] is also in agreement to the other two precautions we put in place. We do not think the accusations are true, d/t the resident having a history of making false accusations and the head-to-toe assessment being completed, no issues found.</p> <p>The Incident Report revealed the following information</p> <p>a. Date of Incident: December 6, 2024</p> <p>b. Time of Incident: Approximately 5:00 AM</p> <p>c. Incident Overview: On December 6, 2024, at approximately 5:00 AM, [name redacted], ADON was notified of a potential incident involving a resident, Resident #52, and [name redacted], CNA. [name redacted] promptly escalated the matter to [name redacted], Administrator, who then notified [name redacted], Director of Nursing (DON). A full investigation into the incident was immediately conducted .Following the initial report, [name redacted] (CNA) was immediately sent home pending the outcome of the investigation to ensure resident safety and to allow for an impartial review. Interviews were conducted with all employees involved, and their statements were documented as part of the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 12/11/24 at Resident #52 self propelled herself in her wheelchair in the hallway near the front entrance. She was dressed in clean clothes and her hair combed.</p> <p>During an interview on 12/11/24 at 2:50 PM, Staff A, ADON stated she was notified of the incident at 5:15 AM with Resident #52 and a the CNA that got her up that morning and then Staff A called the DON and Administrator was instructed to come to the facility and get statements on the incident. She stated she got to the facility around 5:50 AM and got statements from everyone involved in the incident.</p> <p>During an interview on 12/12/24 11:58 AM, the Administrator queried on the reason why they did not report the incident on 12/6/24 and he stated the requirements of abuse did not occur and so they did not think they needed to report it.</p> <p>During an interview on 12/12/24 at 12:07 PM, the Administrator stated it seemed to be a pattern with Resident #52 and after we investigated it, it seemed more of a behavior, and that was why we didn't report it.</p> <p>The Facility Abuse Prevention, Reporting, and Investigation Policy (no dated indicated) revealed the following reporting abuse:</p> <p>a. Mandatory Reporting: All abuse allegations must be reported immediately to the Abuse</p> <ol style="list-style-type: none"> 1. Coordinators: Administrator and DON 2. Timeframe: Within 2 hours if the allegation involves serious harm; Within 24 hours for all other allegations. <p>b. Notification:</p> <ol style="list-style-type: none"> 1. The Abuse Coordinators will notify the following parties as required: Iowa Department of Inspections, Appeals, and Licensing (DIAL)

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338</p> <p>Based on clinical record review, staff interview, and facility policy review the facility failed to ensure the Ombudsman notified of resident transfers to the hospital for 2 of 2 residents reviewed for hospitalization (Resident #37, Resident #110). The facility reported a census of 124 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #110 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition.</p> <p>Review of the Progress Note dated 9/20/24 at 11:12 AM revealed, in part, The ambulance was called, and the resident left the facility via non-emergency ambulance at 2022.</p> <p>Review of Ombudsman Notification provided by the facility did not include notification of Resident #110's transfer to the hospital on 9/20/24.</p> <p>47336</p> <p>2. The MDS assessment dated [DATE] revealed Resident #37 scored a 13 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed medical diagnoses of neurogenic bladder, diabetes mellitus, and heart failure. The MDS revealed the resident used an indwelling catheter.</p> <p>The Care Plan revealed a focus area dated 3/15/23 for suprapubic catheter related to neurogenic bladder. The interventions dated 3/15/23 revealed observation/monitored/documentated any signs and symptoms of complications for pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns with notification to the MD (Medical Doctor) as needed with concerns.</p> <p>A review of Progress Notes revealed:</p> <p>a. On 9/5/24 at 6:30 AM, Resident #37 went to the emergency room via ambulance on at 7:14 AM. on 9/5/24. The resident returned to the facility at 1:56 PM.</p> <p>b. On 10/11/24 at 3:20 PM, Resident #37 went to the emergency room via ambulance.</p> <p>The facility lacked documentation of the ombudsman notification for Resident #37 for the months of September and October.</p> <p>During an observation on 12/09/24 at 12:31 PM, Resident #37 sat in his electric wheelchair in his room and watched television and dressed in clean clothes.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/12/24 at 11:53 AM, the DON (Director of Nursing) queried on when they notified the ombudsman and she stated when they had a discharge, a transfer to the hospital if they were gone over 24 hours, or a death. The DON informed of Resident #37 two transfer/discharge to the hospital and Resident #110 transfer to the hospital and no documentation found for the ombudsman notification and she stated they would check again.</p> <p>During an interview on 12/12/24 at 12:21 PM, the Administrator stated he looked through records again and he didn't see any documentation the ombudsman notified for Resident #37 or Resident #110. The Administrator stated he expected the notification to be sent.</p> <p>The Facility Ombudsman Notification for Discharges and Transfers (no date indicated) revealed the following:</p> <p>a. The Social Services Director or designee is responsible for notifying the Iowa Long-Term Care Ombudsman within 24 hours of issuing the written notice to the resident.</p> <p>b. Notification will include:</p> <ol style="list-style-type: none"> 1. Resident name 2. Reason for discharge/transfer 3. Location and date of the planned move 4. A copy of the discharge/transfer notice <p>c. Notification may be sent via secure email, fax, or other approved methods as required by the Ombudsman office.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336</p> <p>Based on record review, interviews, and the facility policy, the facility failed obtain a lab for a hemoglobin A1c per the provider's order for 1 of 25 residents reviewed for professional standards (Resident #35). The facility reported a census of 124 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 scored a 7 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition severely impaired. The MDS revealed a diagnoses for diabetes mellitus (DM). The MDS revealed the resident received insulin injections 7 out of 7 days. <p>The Care Plan revealed a focus area for potential for complication of diabetes with concern of hypoglycemia/hyperglycemia dated 3/30/23. The interventions dated 3/30/23 indicated medications, labs, and treatments as ordered/accepted.</p> <p>The EMR (Electronic Medical Record) revealed a diagnosis for Type II DM with diabetic peripheral angiopathy without gangrene.</p> <p>The Progress Note dated 9/25/24 at 6:29 PM, revealed new orders per [name redacted]: 1) Hgb A1c dx (diagnosis) of dm2 (Type II diabetes mellitus).</p> <p>The EMR revealed an order for an Hgb A1c with a start date of 9/26/24, end date of 9/26/24, and a completed status for the order.</p> <p>The facility lacked documentation of the results of the Hgb A1c completed on 9/26/24.</p> <p>During an interview on 12/11/24 at 2:46 PM, Staff A, ADON (Assistant Director of Nursing) stated she found the Hgb A1c completed in May and she looked everywhere for the Hgb A1c ordered in September. Staff A stated she saw the order for the Hgb A1c in September and doesn't know how it was missed.</p> <p>During an interview on 12/11/24 at 4:55 PM, the Director of Nursing (DON) stated the order placed by an agency nurse and all she could say was they missed it and the lab didn't get completed. The DON stated her expectation was when they got an order we will do 3 checks in place that were not in place prior to the survey. The first check was the nurse noted the order and put the order in and then the next nurse noted the order for the lab, and the last check was the ADON or DON reviewed the ordered and make sure the family knew and the lab knew about the order.</p> <p>The Facility Physician's Order- Recording dated 5/2020 revealed the following:</p> <p>a. If laboratory is involved (or according to facility process):</p> <ol style="list-style-type: none"> 1. Make out lab slip 2. Notify lab. <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Enter notation on calendar for any future labs to be drawn. Indicate any special instructions</p> <p>4. document in nurse's notes</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45338</p> <p>Based on observation, interview, and facility policy review the facility failed to ensure a medication cart remained locked when not in use for 1 of 7 medication carts. The facility reported a census of 124 residents.</p> <p>Findings include:</p> <p>On 12/9/24, observation of the medication cart for 400 hall present across from the nursing station revealed the following:</p> <p>a. On 12/9/24 at approximately 2:12 PM, a staff member walked past the medication cart and the medication cart lock was not depressed. Another staff member then passed by the medication cart and the medication cart lock was not depressed. The cart was unlocked, able to be opened without a staff member present, and medications were observed to be accessible inside the medication cart.</p> <p>b. On 12/9/24 at 2:13 PM, notified Staff B, Registered Nurse (RN) of the medication cart, who was present in the office off of the nursing station. Staff B queried about when medication cart was normally locked, and explained when not here.</p> <p>On 12/12/24 at approximately 11:00 AM, the Director of Nursing (DON) queried when staff should be locking the cart, and responded when not by it, using it, and acknowledged needed to be in their sight.</p> <p>The Facility Policy titled Medications Labeling and Storage, dated April 2008 revised November 2024, revealed the following: 4. All medications will be stored appropriately, either in the locked medication cart or medication room.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>48374</p> <p>Based on observation, resident and staff interviews, and temperature testing, the facility failed to serve food at a palatable temperature for one dinner meal observed and for several residents served room trays on the evening meal in the rooms on the 600 Hall. The facility reported a census of 124 residents.</p> <p>Findings include:</p> <p>During an interview on 12/10/24 at 12:26 PM, Staff D, Dietary Aid stated food temperatures are taken once the food has been placed in the steam table and before the first resident is served. Staff D was asked how they keep the room trays hot when taking meal trays to the resident rooms. She advised the plates and food covers are not heated prior to plating. She reported they typically try to get the meals to the resident rooms as soon as possible after they have been plated. When queried Staff D, stated she has heard a few random complaints that sometimes the food is not hot enough. Once the food is delivered to her it is placed in the steam table and temperature taken and logged into a log book prior to starting meal service. The log book was observed and temperatures were documented.</p> <p>On 12/10/24 at 4:10 PM an observation of evening meal temperatures was conducted in the kitchen prior to the food going out to the individual kitchenettes. The temperatures of the food going to Dining Room D were as follows prior to leaving the main kitchen.</p> <ul style="list-style-type: none"> a. Turkey burgers-178 degrees F (Fahrenheit) b. Sweet potato mashed-166 degrees F c. Baked potatoes-202 degrees F d. Sweet potatoes-172 degrees F e. Pureed turkey burger - 178 degrees F f. Ground turkey burger-166 degrees F g. Mashed potatoes-193 degrees F h. Gravy-204 degrees F i. Alternate vegetable-tomato soup-186 degrees F <p>On 12/10/24 at 5:50 PM the last meal tray was delivered to the residents and the meal items on the test tray were temperature checked by the Culinary Director. The following were the temperature results on the test tray food items. The items were tested with the Culinary Director's thermometer:</p> <ul style="list-style-type: none"> a. Pea salad - 48 degrees F <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. Turkey burger-118 degrees F</p> <p>c. Sweet potato fries-116 degrees F</p> <p>When queried, the Culinary Director advised the above food temperatures were not good.</p> <p>On/10/24 at approximately 6:00 PM Staff C, Certified Nursing Assistant (CNA) stated that she knows that the food temperatures are checked prior to serving but she is unsure what the food temperatures should be. She advised she is a CNA so she just helps out when needed and doesn't know the specifics.</p> <p>During an interview on 12/12/24 at 11:22 AM, the Culinary Director stated the temperatures weren't good, I was expecting the pea salad citation. It did not maintain a cold enough temperature. She stated since the turkey burgers were in juice she was surprised the temperature was as low as it was. The Culinary Director stated she thinks part of the problem was we were running behind. Fries are pretty hard to keep warm. I will meet with management and we will develop an effective system to serve meals at the appropriate temperatures.</p> <p>A review of an undated facility policy, titled The Dining Experience: Staff Responsibilities Policy statement declared The dining experience will be person centered with the purpose of enhancing each individual's quality of life and being supportive of each individual's needs during dining. Individuals will be provided with nourishing, palatable, attractive meals that meet daily nutritional, and/or special dietary needs and food preferences and are served at a safe and appetizing temperature. Individuals will be provided restorative dining services as needed to maintain or improve eating skills.</p> <p>The Procedure section, #14 directed food will be at the proper temperature, texture and/or consistency to meet each individual's needs and desires.</p>