Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165552	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Vinton Lutheran Home	1301 Second Avenue South Vinton, IA 52349

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 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** 19126 Based on clinical record review, staff and resident interviews, and observations the facility failed to follow their policy and procedures regarding intravenous therapy for 1 of 5 residents reviewed (Resident #2). The facility reported a census of 44 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #2 had diagnoses which included pneumonia, septicemia, and diabetes mellitus. The resident had a Brief Interview for Mental Status score of 13 out of 15, which indicated she had intact cognitive ability. The resident received daily antibiotics via a peripheral inserted central catheter (PICC line). Review of the Care Plan dated 10/17/24 informed the staff the resident had dehydration and required fluid maintenance related to pneumonia. The Care Plan directed the staff to administer intravenous antibiotic therapy once daily for severe sepsis. Review of a Progress Note dated 11/3/24 at 9:00 pm revealed Staff E-RN attempted 3 times to place a peripheral intravenous line in Resident #2 as requested by Staff F-RN/Director of Nurses. The Progress Notes on 11/3 at 11:40 pm revealed Staff E-RN could not administer the ordered antibiotic via the PICC line due to the base of the PICC port leaking blood after she changed the resident's PICC line dressing. The notes indicated Staff E had difficulty removing the dressing as it was adhering/sticking too strongly. Staff E documented she was able to tape the base of the port to prevent leaking and would continue to monitor the line. (continued on next page)

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Staff E-RN on 12/3/24 at 9:00 am, Staff E stated she worked the night shift from 6 pm-6 am 11/3-11/4/24 and was responsible for the administration of the IV antibiotic for Resident #2. Staff E indicated between 8-9 pm on 11/3 she changed the resident's PICC line dressing prior to administering her antibiotics via the PICC line. The RN indicated she had difficulty changing the dressing as it was not changed when scheduled but was 3 days late, she indicted she had to use scissors to cut some of the dressings but reports she did not cut the PICC line. The RN stated the dressing was stuck firmly to the resident's skin and difficult to remove. She indicated she finally got the dressing changed and attempted to flush the PICC site with a maintenance flush of 10 cc of sodium chloride as per the order but could not flush the site. At that time she noted the resident had bloody oozing from the the line directly above the hub. Staff E stated she inspected the tubing and hub but couldn't find a break or cut in the line but the resident continued to have bloody drainage. Staff E said she first attempted to place tape on the tubing but it did not stop the oozing of blood. Staff E wanted to stop the leak so she placed a drop of glue on the PICC line tubing, she reported the bloody oozing stopped. The RN stated she waited about 20-30 minutes after placing the Gorilla glue on the tubing before she attempted to flush the PICC line. She stated she could not flush the PICC line as the line seemed to be occluded. Staff E said due to this she could not administer the resident's antibiotic as ordered. Staff E called Staff F-RN/Director of Nurses who directed her to place a peripheral line in the resident to administer the antibiotic but she was unable to place the IV after 3 attempts. She again called Staff F who stated to wait until the morning and she would contact the physician for orders. Staff E-RN stated the policy was to call the Physician when leakage is noted from the PICC line. The policy does not direct the staff to place glue on the PICC line. She stated it was a poor judgement call and does not know why she did it. Review of a Progress Note dated 11/4/24 revealed Resident #2 went to a local emergency room to have another PICC line inserted in order to receive the remainder of her antibiotic therapy. During an interview with Staff F-RN/DON on 12/2/24 at 11:30 am, Staff F stated Resident #2 initially had her PICC line inserted on 10/9/24 due to sepsis, on 11/4/24 the resident had another PICC placed at a local emergency room . Staff F-DON spoke with the resident's physician on 11/4 who reported somehow the PICC line got cut. Staff F stated Staff E-RN called her to report the resident's PICC line was leaking on 11/3, she directed the RN to place in a peripheral line but the RN was not successful. Staff F stated she spoke with the resident's primary care physician who wanted the PICC line replaced. The resident went to the emergency roiagnom on ,d+[DATE] to have it replaced. Staff F-DON stated the emergency room staff were not happy when they discovered Staff E-RN tried to fix the leaking PICC line with glue. Staff F-DON stated Staff E-RN should have called the emergency room and sent her out for a new PICC line. The resident did miss one dose of antibiotic that day but did finish up her prescribed course of antibiotic therapy. During an interview with Staff I-LPN/ADON on 12/2/24 at 2:45 pm, Staff I stated when she spoke to Staff E-RN regarding Resident #2's PICC line, the RN indicated she did not cut the line but that it pulled apart when she was changing the dressing to the insertion site. Staff E-RN informed Staff I-ADON that she placed glue on the PICC line tubing to stop the leakage. Staff I-LPN/ADON stated the resident's Primary Care Physician made rounds in the facility on 11/5/24 and commented to Staff I that they should review the policy regarding PICC lines with their staff. Staff I-LPN/ADON stated she would have expected Staff E-RN to place tape on the PICC tubing line, call the doctor and send her to the emergency room . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #2's Primary Care Physician on 11/4/24 at 11:30 am, the PCP stated the PICC nurse told her that the resident's PICC line was cut and that the facility nurse put glue on the cut She stated the resident was alert and oriented and made these comments to her nurse when she was replacing her PICC line. The PCP stated this is not a good practice as the glue could dislodge and get into the resident's blood stream which could result in an embolus. Review of a local emergency room procedure note dated 11/4/24 at 1:00 pm, the note revealed Resident #2 presented to the emergency room for a change in PICC line as the PICC line was damaged at the facility. The PICC line was replaced with a peripheral line as the resident only had several doses of antibiotics left. The dressing from the PICC line was removed by the hospital staff and at that time the patient reported the facility staff accidentally cut the PICC line and it started to bleed. The resident indicated to the hospital staff the nurse at the facility used glue to put it back together and to help stop the bleeding. The facility nurse wrapped it with tape to help keep it together. The resident returned to the facility after the new IV was placed. Review of the facilities Intravenous Therapy Policy and Procedure updated 2/1/2024 in regards to PICC Line/Midline Catheter Maintenance directed the staff of evaluate residents at least every shift for evidence of cannula related complications. The staff should notify the resident's physician and the DON if any of the following are noted: a. swelling or pain in the affected arm, chest or neck b. fluid leaking from the site or damaged catheter c. neck vein distension d. catheter migration either in or out e. excess bleeding or drainage from the catheter site f. redness or swelling in the insertion site g. pain or discomfort during the IV infusion h. numbness or tingling in the affected extremity i. any time there is a concern

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 20331 Based on observation, clinical record review, facility policy review, and staff interviews, the facility failed to provide appropriate supervision while transporting a resident in the wheelchair that resulted in injury for one of three residents' reviewed. (Resident #1). The facility reported a census of 44 residents. Findings include: The MDS (Minimum Data Set) dated 10/10/2024 revealed Resident #1 had severe cognitive impairment, required substantial/maximum assistance of staff for transfers from one surface to another, and used a wheelchair for locomotion. The resident had diagnoses including Alzheimer's disease, osteoarthritis and hypertension. Resident #1's Care Plan revealed the resident required assistance with ADL's (activities of daily living) related to cognitive decline, created on 2/2/2021. The Care Plan instructed staff to transfer the resident with an E-Z stand (mechanical) lift, provide her with a wheelchair for locomotion, and allow her to self propel. On 8/2/2022 the Care Plan identified the resident had a fall risk related to incontinence, impaired daily decision making skills, decreased cognition, and pain. On 10/16/2024 the Care Plan instructed staff to assist the resident to sit in the dayroom recliner for closer supervision. On 11/2/2024 the Care Plan revealed the resident had a fall that resulted in a facial injury and fracture. It directed staff to provide a mechanical soft diet and nosey cups (a drinking cup with a cut out on one side), administer antibiotic Cephalexin four times a day for ten days, and monitor the bruises. On 11/4/2024 the Care Plan directed staff to remove sutures on top of her nose. The resident's nurse Progress Notes included: 11/2/2024 at 8:30 A.M., Staff D, LPN (Licensed Practical Nurse) responded to a call for help from the memory care unit. Staff D observed Resident #1 on the floor. Staff D learned the resident sustained a fall while being transported to the dining room table in her wheelchair. The resident's foot got caught, she fell forward and hit her head and nose on the table. Staff D applied pressure to the wound while Staff A, RN (Registered Nurse) called the family. EMS (Emergency Medical Services) transported the resident to the ER (emergency room) and she returned at 12:30 P.M. with orders to monitor the right and left orbital bruises until healed, and administer Cephalexin for ten days. 11/3/2024 - the physician ordered a mechanical soft diet with nosey cups due to the resident's facial fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	11/4/2024 - statements were obtained and investigation completed. Resident #1 got her foot caught while being transported approximately four feet to the table. The resident fell forward, hitting the table. 11/14/2024 - stitches removed, area healed without drainage. The facility Fall Scene Investigation Report initiated 11/2/2024 revealed Resident #1 fell at 8:30 A.M. while being placed closer to the table. The resident's foot got caught in the wheelchair and the resident fell forward, hit her nose on the table and landed on the floor on her side. The resident sustained a laceration to the nose. Staff determined the immediate intervention for this fall was to add foot pedals during transfers. Resident #1's Emergency Department note dated 11/2/2024 at 9:26 A.M. included: Chief complaint: Fall and facial laceration (oozing complex laceration to bridge of nose). Patient fell with forward lunge out of the wheelchair approximately one hour prior to arrival. She was reportedly in a wheelchair when a wheel got stuck while the staff pushed it, causing the resident to fall forward out of the wheelchair. Physical Exam: Raccoon eyes, contusion and laceration present. There is a V-shaped, 4 cm (centimeter) laceration over the bridge of the nose and bruising to bilateral orbits and forehead. There is bruising and swelling over bilateral knees. CT findings: Comminuted (a bone that is broken in at least two places), displaced fracture of the nasal bone with soft tissue swelling. Associated fracture of the anterior (nearer the front) nasal septum. ED staff sutured the resident's 4 cm. nasal laceration with 10 sutures, and applied antibiotic ointment and a bandage. The resident discharged with orders for an antibiotic, pain medication, fall precautions, no straws, no blowing the nose, and ice to the area up to four times a day for pain control. The Wound - Weekly Observation Tool dated 11/2/2024 included: 1. Left Eye - Bruise. 50 mm (millimeters) length and 70 mm width. Initial assessment. 2. Right Eye - Bruise. 50 mm length and 85 mm width. Observation on 12/2/2024 at 9:20 A.M. revealed Resident #1 seated at the dining room table with activity staff. The resident sat in a wheel chair with foot pedals and a foot buddy (cushion). The resident wore gripper socks, glasses, and appeared alert and interested in the activity. The resident's face had a healed nasal laceration and no bruising. Staff G and Staff H, C.N.A. removed the resident from the table, transported her to the lounge, and transferred her using a stand up mechanical lift from the wheelchair to a recliner. Staff explained the procedure and the resident remained calm. The resident, nonverbal at the time of the observation, had no response to questions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/2/2024 at , Staff F, RN (Registered Nurse), DON (Director of Nursing) reported Resident #1 fell on Saturday, 11/2/2024. Staff F received a call regarding the fall and she instructed staff to send the resident to the ER. Staff F learned Staff G, C.N.A. pushed the resident in the wheelchair without foot pedals. The resident fell forward, hit her face on the table. Staff wrote statements and Staff F did an investigation on Monday, 11/4/2024. Staff G indicated the resident normally self propelled, but she knew she should have applied the foot pedals. Staff F put out an education for all staff to read and sign regarding the need for foot pedals with all residents in wheelchairs. If the resident self propels the wheelchair, the foot pedals need to be off to the side. Staff G received education and a one day suspension, and could lose her job if she had another same incident. Orientation to the facility always includes transfer assistance. On 12/2/2024 at 9:30 A.M., Staff G, C.N.A. reported working for two years at the facility. On 11/2/2024 the resident sat in the wheelchair about three feet from the dining room table. Staff G positioned the resident in that spot after she got her up and ready for the day. Normally, the resident would self propel the wheel chair. When breakfast began, Staff G moved the resident closer to the table without foot pedals. Normally, the resident would move her feet, however she must have gotten her foot stuck. The resident leaned forward, hit her face on the table. Staff G pulled the wheelchair away from the table so she could attend to the resident. Staff H, C.N.A. grabbed a wash cloth to place on the resident's bleeding nose, and Staff A, RN came from the medication cart to assist. Other staff came to assist, the resident transferred to the ER and returned with sutures. Staff G wrote a statement and received education regarding the need for foot pedals on all wheelchairs during transport. Staff G also received a one day suspension without pay. Staff G learned during C.N.A. classes the need to apply foot pedals when transporting a resident in a wheelchair. On 12/2/2024 at 9:50 A.M., Staff A., RN reported working on 11/2/2024 when Resident #1 fell . Staff A heard the resident fall as she passed medication nearby. Staff A saw Staff G push the resident forward, the resident hit her nose on the table and fell out of the wheelchair. Staff G reported the wheelchair had no foot pedals, and resident got her foot caught, twisted it, and fell forward. Now, they make sure foot pedals are always used. If a resident self propels the wheelchair, the foot pedals are off to the side. Staff F put up a form for staff to read and sign regarding the use of foot pedals. In the past, Resident #1 would self propel the wheel chair around the unit. On 12/2/2024 at 10:20 A.M., Staff B, C.N.A. reported working on 11/2/2024 when Resident #1 fell . Staff B sat at the dining room table assisting another resident with breakfast when Staff G pushed the resident to the table. Staff B heard a loud thud and the resident said ouch when she landed on the floor. Staff B grabbed a towel and applied it to the resident's nasal laceration. Staff B knew to always use foot pedals when transporting residents. Staff received re-education after the incident. On 12/2/2024 at 10:00 A.M., Staff H, C.N.A. reported she did not work in the memory unit on 11/2/2024. Since Resident #1's incident, they received education regarding the use of foot pedals. Staff H learned during C.N.A. class that foot pedals were required when transporting a resident. Resident #1 could self propel the wheel chair and enjoys wandering around the unit. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/3/2024 at 10:30 A.M., Staff C, C.N.A. reported working full time in the memory care unit on the night shift. Resident #1 enjoys scooting around the unit in her wheel chair, and often carries a baby doll. Staff need to have foot pedals on Resident #1's wheelchair because she puts her feet on the floor and attempts to stop staff from pushing her. Even with foot pedals, the resident will attempt to put her feet on the floor. The resident now has a foot buddy on the wheelchair. After the resident's fall, staff received education regarding the facility policy that all wheelchairs must have foot pedals if you are transporting a resident. On 12/2/2024 at 11:00 A.M., Staff D, LPN reported working on 11/2/2024 when Resident #1 fell . Staff D responded to a call for assistance in the memory care unit. Staff D observed the resident on the floor with Staff G holding a wash cloth over the resident's nose. Staff D took Staff G's place and comforted the resident while other nursing staff called the family and physician. After the incident, all nursing staff received education regarding the need for foot pedals on all wheelchairs at all times. According to the facility Progressive Discipline Notification, Staff G received a written discipline signed on 11/4/2024, related to pushing a resident without foot pedals that resulted in the resident falling and hitting the table and floor. The resident received multiple facial fracture. Staff G received education regarding the need for foot pedals, and another incident will result in disciplinary action up to termination. Staff G served a one day suspension without pay on 11/11/2024. The facility Wheelchair Policy dated May 1, 1997 and reviewed February 1, 2024 included: Policy: to give guidance to employees when assisting residents in wheelchairs. 1. Resident will be assisted in wheelchair correctly and safely. 2. Staff will assist resident without strain or injury to self or resident. 3. Staff will explain to resident safety measures: a. Place hands on arms of wheelchair or in lap. b. Place feet on wheelchair pedals. Residents are not to be pushed in wheelchair without resident's feet on pedals. Any resident who would like at times to self propel, may fold pedals in an upright to do so. Only resident's who always propel themselves in the wheelchair, may be without foot pedals on their wheelchair. c. If foot pedals are missing, staff shall obtain foot pedals for wheelchair. d. If foot pedals are unavailable for any reason, residents shall self propel wheel chair until able to obtain. e. Interventions shall be implemented if residents are unable to safely keep feet on wheel chair foot pedals. f. If staff are noted pushing residents without foot pedals, discipline/education shall be given up to and including termination. (continued on next page)

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