STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165552	A. Building B. Wing	04/22/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48452 Based on observation, record review, interview, and facility policy review the facility failed to take a resident to the restroom timely to prevent his brief from soiling his clothing for 1 of 3 residents reviewed (Resident #46). The facility further failed to ensure resident's fingernails were cleaned and trimmed for 1 of 3 residents reviewed (Resident #21). The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #46 dated 3/28/24 included diagnoses of non-Alzheimer's dementia and anxiety. The Brief Interview for Mental Status (BIMS) documented a score of 1, which indicated severe cognitive impairment. It documented the need for substantial/maximal assistance with toileting with the helper completing more than half of the effort. The Care Plan focus area for Resident #46, initiated 9/27/23, documented he was at risk for pressure ulcer/skin breakdown related to frequent urine incontinence. A section titled falls documented risk related to incontinence. An area titled ADL (Activities of Daily Living) function noted the resident required assistance with toileting. A focus area titled bladder & bowels indicated the resident was frequently incontinent of urine. Interventions included the resident wore a pull up for incontinence products with a toileting program of check and change. The Care Plan lacked a check and change time frame. A Progress Note dated 4/18/24 at 2:33 PM, documented as a late entry and titled Behavior Note, documented the reason the resident spent most of the shift going into another resident's room was to look for the bathroom. On 4/17/24 the following was observed: 10:52 AM - The resident walked towards his room from the common area television. He had a grapefruit sized dark grey area on his light grey pants near the base of his brief on the left leg. (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

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 04/22/2024
NAME OF PROVIDER OR SUPPLIER The Vinton Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 Second Avenue South Vinton, IA 52349	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:57 AM - The resident pulled at the back left leg of his pants with his left hand. Staff B, Certified Nursing Assistant (CNA), redirected him to his room and went into another room. When Staff B shut the door the resident swore and pushed at the door frame. He walked back to the chair in the common area and sat down with the wet spot of his pants on the seat of the chair. He got up and walked to Staff A, Licensed Practical Nurse (LPN). She asked if he had to go to the bathroom. He said yes. She said the girls would be out soon and walked away. 11:04 AM - The resident sat in the common area chair with wet pants. 11:12 AM - The resident walked towards another resident's room. The stain remained on the back of his left leg. Staff A redirected him to his bathroom and she walked away. 11:17 AM - Staff A told the CNAs the resident was waiting for them. 11:20 AM - The Staff B and Staff C, CNA, helped another resident move from a recliner to a dining room chair. 11:22 AM - The resident left his room. He adjusted the waistband of his pants and pulled at the stained area. He returned to his chair in the common area and sat down. 11:25 AM - Staff B asked the resident if he had to use the restroom. The CNAs walked him to his room, one on each side. Observed the brief was full enough to push his pants downward, exposing the waistband of the brief. The stain remained. 11:35 AM - The resident left his room in different pants and Staff C carried his bagged pants to the laundry. The facility failed to sanitize the chair the resident sat in with wet pants before he sat down again for lunch. On 4/18/24 at 10:22 AM Staff C stated Resident #46 could sometimes take himself to the restroom. She acknowledged he needed to be changed the day before due to a wet spot on his pants and stated two staff were needed to take him to the restroom due to combative behavior. On 4/22/24 at 11:16 AM Staff E, Housekeeping, stated she didn't clean the furniture in common areas. An interview with Staff D, Housekeeping/Laundry Director on 4/22/24 at 11:21 AM revealed furniture was supposed to be sprayed once per day. A policy titled Furniture Cleaning reviewed by the facility 4/3/24 documented furniture was expected to be clean and odor free. Staff were expected to use a diluted solution of quaternary disinfectant cleaner, a pad center or utility pad solution, and wipe down the entire piece of furniture working from the top down when soiled. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment for Resident #21 dated 2/22/24 included diagnoses of non-Alzheimer's dementia, aphasia (loss of ability to understand or express speech), and hemiplegia/hemiparesis (weakness/inability to move one side of the body). The Brief Interview for Mental Status (BIMS) documented a score of 0, which indicated severe cognitive impairment. It documented the need for partial to moderate assistance with personal hygiene. The Care Plan focus area for Resident #21, initiated 10/7/20, documented she required assistance with ADLs related to weakness secondary to diagnoses of epilepsy and and history of CVA (cerebral vascular accident). An intervention dated 10/8/20 included offer bath/shower two times per week and as needed, providing assistance. A focus area created 1/30/23 documented cognitive loss with a diagnosis of dementia. Interventions included re-approaching resident at a later time if agitated, and determine resident's physical and mental limitations and adjust accordingly. Another focus area titled behaviors dated 9/22/20 documented if behaviors are noted staff will attempt to determine root cause. The Care Plan lacked documentation of personal care refusal. An activity log titled Manicures dated 4/8/24 at 1:30 documented Resident #21 refused participation in the group activity. Progress Notes dated 4/5/24 to 4/16/24 lacked documentation of the resident's refusal of nail care, root cause, or attempted re-approaching. A Progress Note dated 4/17/24 indicated the resident's nails were cut and cleaned. On 4/15/24 at 11:07 AM observed staff take the resident her meal. Staff did not ask the resident if she wanted to wash her hands prior to eating. On 4/16/24 at 09:42 AM observed the resident's nails were chipped, varied lengths, and a thick brown substance with white flecks was noted under all of the nails on her left hand. On 4/17/24 at 10:38 AM observed the resident reading in her recliner. The nails on her left hand remained long with brown and white matter underneath all 5 nails. She repeatedly touched her book page, her hair, her face, and ate popcorn with that hand. An interview with Staff A on 4/17/24 at 12:49 PM revealed that the resident had a scabbed area on her forehead that was cancerous. She picked at it regularly and would sometimes decline treatment. She stated that could be what was under her nails. She didn't know why they were not cleaned and said if the resident was not diabetic a CNA could do it. An interview with the ADON on 4/18/24 at 10:06 AM indicated if a resident was not diabetic a CNA could trim nails. A CNA could always clean a resident's hands. If residents were diabetic a nurse would clip them. On 4/22/24 at 11:34 AM the Administrator stated they had documentation the resident refused a manicure on 4/8/24. He said he could not expect the activities staff to go back 100 times and ask her again. A policy titled Resident's [NAME] of Rights, reviewed by the facility 3/1/23, documented the resident's right to be treated with dignity and respect, and to be free from abuse and neglect.

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on record review, resident interview, and staff interview the facility failed to complete a Preadmission Screening and Resident Review (PASRR) for 1 of 1 residents reviewed (Resident #8). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS listed diagnoses of Anxiety Disorder, Depression, and Bipolar Disorder. A document with a mailing date of 6/28/19 titled Status Change Review Outcome documented a current PASRR Level II Summary of Finding report, dated 4/30/19 remained valid for the resident's nursing facility stay. The summary report on Page 6 revealed the resident was approved for 150 days of nursing facility care. The facility lacked documentation that a follow up PASRR was completed. On 04/15/24 at 10:38 AM the resident stated she lived here because of her mental illness. She could do a lot of things independently but needed help taking care of herself. On 04/18/24 at 02:49 PM an interview with the DON confirmed that Resident #8 has not had a PASRR completed since 2019. She confirmed she was responsible for PASRR completion.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48374 Based on observation, clinical record review, and staff interviews, the facility failed to reassess the effectiveness of fall interventions and to modify the resident's care plan to meet the resident's needs for 1 of 1 Residents reviewed (Resident #4). The Care Plan failed to identify specific staff interventions to mitigate future falls. The facility reported a census of 50 residents. Findings include: The Re-admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #4 identified a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. The MDS documented the resident had diagnoses of fracture of left femur, cancer, arthritis, osteoporosis, and malnutrition. The MDS documented the resident required substantial/maximal assistance for mobility and walking was not attempted due to medical condition or safety concerns. The Care Plan initiated 4/24/14 with a target date of 4/10/24 identified the resident at risk for falls. The Care Plan informed staff the resident often attempted to ambulate independently and encouraged staff to keep call light within reach at all times when in room. Resident is at risk for falls related to possible side effects of medications and incontinence. The Care Plan documented the following falls: a. 9/12/23 Fall no injury b. 9/27/23 Fall hit head c. 2/22/24 Post fall no injury d. 2/24/24 Post fall noted injury The Care Plan lacked documentation regarding the following falls: a. 2/2/24 Fall no injury b. 3/12/24 Fall with Major injury The Fall Scene Investigation Report dated 2/2/24 documented a brief summary of how fall happened: resident was getting up to go to the bathroom. The resident was not care-planned for hourly checks. No injury noted. Invention for this fall-continue to educate resident to call for assistance and increase visual checks. The Fall Scene Investigation Report dated 2/24/24 documented a brief summary of how fall happened: resident stated she was trying to reach gait belt on bed so she could go to the bathroom. The resident was not care-planned for hourly checks. No injury noted. Intervention for this fall-reminded to use call light. Keep items within reach. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fall Scene Investigation Report dated 3/12/24 documented a brief summary of how fall happened: resident up walking by self and lost balance landing on left hip. The resident is care-planned for hourly checks. Checks were completed as care-planned. Injury to left hip. Intervention for this fall-Sent to ER broken hip. Documentation provided by the DON titled, February 2024 Post Falls documented on 2/2/24 resident got up to take herself to the bathroom. Found lying on left side at an angle by bed. No injuries noted. Intervention: Continue to educate resident to call for assistance and increase visual checks. Resident was added to Falling Star Program on 2/4/24. Documentation provided by the DON titled, February 2024 Post Falls documented on 2/24/24 resident stated she was trying to reach for gait belt on bed so she could go to the bathroom. No injuries noted. Intervention: Remind to use call light. Keep items within reach. Documentation provided by the DON titled, March 2024 Post Falls, Follow up 4/3/24 documented on 3/12/24 resident was up walking by herself and lost balance landing on left hip. Noted pain in left hip. Intervention: Sent to hospital for evaluation: (Dx: Fractured left hip) Follow up: No other falls noted. Resident was readmitted to hospice. Has not been getting out of bed much per her request. The Progress Note dated 3/12/24 18:36 Health Status Nursing Note Text: resident got up and walked by self and fell in room and when nurse got to room resident was sitting on left side and c/o left hip and pelvis pain resident was unable to move so son called and wanted her to be sent to local hospital for evaluation, 1800 ER notified and gave order to transport, hospice notified of need to transfer and they agreed, will meet resident at ER, son will meet at ER, DON and ADON notified 1828, ambulance arrived and 1840 left facility with resident. The Progress Note dated 3/12/24 21:43 Health Status Nursing Note Text: This nurse called to check on the resident's condition. She was admitted to another hospital with diagnosis of a fractured left hip. In an interview on 4/17/24 at 4:55 PM with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the DON advised Care Plan interventions are not necessarily updated or documented on the resident's Care Plan but the interventions are documented on the mini Care Plans located on the inside of the resident's wardrobe cabinets. The mini Care Plan from this resident's room was retrieved and reviewed with both the DON and the ADON. The DON advised this resident's mini Care Plan interventions are updated and referenced the bottom left corner of the stock card where reportedly the undated and illegible documentation reads *transfers-toe touch to left leg, wheelchair only. No ambulation. The mini Care Plan provided had numerous hand written revisions and items written on it with various dates with some entries highlighted. When queried, the DON advised the highlighted areas are discontinued and the staff member would know of the revisions because they are also discussed during report at the start of shift change. If a staff member is absent upon their return they would know to refer to the mini Care Plan for updates. The DON advised she failed to date the most current revisions on resident #4 mini Care Plan. The DON also advised this resident was placed on the Fallen Stars list which denotes the resident is a fall risk by a purple wrist band. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/18/24 at 10:56 AM, Staff F, Certified Nurse Aide (CNA), stated the mini Care Plans are in the resident's rooms. She stated the Care Plans are in the resident's closets and they tell them how to care for the resident. For example, how they transfer, how to provide care, if they need tubi grips. Staff F stated there is a star by the room door to let them know if the resident fell . Any new resident interventions are received in report and the nurse puts them on the mini Care Plan. If there are any changes to the mini Care Plans they get this information in report and also look at the mini Care Plan in the resident room and make sure the cares are correct. In an interview on 4/18/24 at 11:08 AM Staff G, Certified Nurse Aide (CNA), stated the mini Care Plans are in the resident's rooms. The mini Care Plan is in the residents closet and is used to see if they are independent or what assistance they need. Staff G stated she usually looks at it every day. The mini Care Plan would tell if the resident wears TED hose, tubi grips etc. Staff G was not sure if fall interventions were on the mini Care Plans but she thinks the interventions are to monitor the resident so they do not get up independently. During report staff are told what the most recent directives are with the residents. Staff G stated the nurses usually date the changes on the mini Care Plans and sometimes they use a yellow highlighter or a red pen. They also will put on the mini Care Plan last reviewed and the date. In an interview on 4/18/24 at 11:20 AM Staff H, Certified Nurse Aide (CNA), advised the mini Care Plans are in the residents rooms and this tells the staff how to transfer, things they need such as dentures, how they transfer and what their mobility is. Staff H advised she thought there were some fall precautions on the mini Care Plans like low bed and mats on the floor. The nurses give them the information in report each morning before the start of the shift. She stated when she was familiar with a resident she doesn't necessarily look at the mini Care Plan every day. If the residents are new she will look at the mini Care Plan to make sure she is doing what she is supposed to. Staff H will also look at the mini Care Plan if she can't remember what the change in intervention was that was shared with them in report. In an interview on 4/24/24 at 11:15 AM the ADON was queried regarding Care Plan and intervention updates. When a resident returns to the facility from the hospital the DON would update the Care Plan. It would be an expectation the Care Plan would be updated with any new orders or new interventions. In an interview on 4/22/24 at 11:28 AM the DON was queried regarding Resident #4 fall with a major injury on 3/12/24 in which she advised this fall was added to the resident's Care Plan. When asked to provide this documentation, upon review, the DON responded, it is not entered on the Care Plan. The facility policy titled The Lutheran Home For The Aged Association-East Policies and Procedures-Fall Assessment and Management Policy and Protocol revised 3/24/22 and reviewed 2/1/24 documented it is to provide guidelines on Fall Assessment and Management. 2. Fall Protocol-In the event of a resident fall, a Nurse shall: (j) Determine immediate interventions/safety measures to be taken by staff to prevent further falls. (k) Interventions/safety measures will be communicated to on duty care staff and added to the mini care plan immediately following fall. Information will be placed on report sheet. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(l) The Director of Nursing or designee will review the Fall Scene Investigation Report for the appropriate intervention(s) to the fall and completeness of the Fall Scene Investigation Report. (m) Interventions for reducing the residents fall risk shall be resident specific and based on the fall in an attempt to prevent the fall from happening again. (n) Interventions shall be followed up on to determine if the intervention is still appropriate. Falling Star Program: 1. Any resident identified by Nurse Managers and/or therapy shall be placed on the Falling Star Program. 2. Indications a resident would benefit from the Falling Star Program include, but are not limited to: a. Residents who are routinely noted ambulating without assistance. b. Residents who are having an increased number of falls. c. New admissions that present with risk factors such as cognitive impairment for 7 days following admission until facility staff can become accustomed to the resident's routine. d. Residents that are noted to be acutely weak due to an acute illness, such as URI, UTI, etc. 3. Residents who are in the Falling Star Program shall have: a. Documentation of this placed in their Plan of Care. b. A Purple Falling Star Magnet placed on the resident's door frame. c. A Falling Star Band placed on the resident's primary mode of locomotion (w/c, walker, cane). 4. The Purple Falling Star Magnet and Band shall alert all staff that the resident is at a high risk for falls and of the increased need for surveillance of the resident's activity when going by them or their room to assure safety. 5. The Falling Star Program may be discontinued per nurse manager and/or therapy judgement.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 48452 Based on record review, interviews, and policy review the facility failed to notify the pharmacist of a resident's admission in a timely manner to complete a drug regimen review (DRR) for 1 of 5 residents reviewed for unnecessary medications (Resident #33). The facility reported a census of 50 residents. Findings include: The MDS for Resident #33 dated 4/1/24 revealed diagnoses of anxiety disorder, depression, and diabetes mellitus II. The entry MDS was dated 11/6/23 and the Medicare 5 day admission MDS was dated 11/13/23. The Medication Administration Record (MAR) documented escitalopram Oxalate 20 mg for depression (11/7/23) and buspirone HCl 10 mg for anxiety (12/6/23). A document titled Doctor's Order Sheet, dated 11/6/23 at 9:00 AM, documented medications were listed on the resident's transfer sheet and was signed by the resident's provider. A document titled Order Summary Report from the resident's prior facility, dated 11/2/23 at 11:53 AM, revealed the resident was prescribed 24 medications at the time of the transfer to this facility. Each page was signed by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) and dated 11/6/23. An untitled, undated document headed with the resident's name, date of birth, room number, and provider documented pharmacy reviews were conducted on 12/5/23, 1/31/24, 2/29/24, and 3/28/24. It included a note that the resident was a skilled new admit on 11/6/23 and a DRR was NOT done initially because it was not requested. It documented a DRR date of 12/5/24. Additional documentation indicated the resident had blood sugars between 53 and 556 in the first month. The section was initialed by the pharmacist. Progress Notes, dated 11/30/23 at 14:02 titled Pharmacy indicated a late entry was made for a monthly pharmacist mediation regimen review was completed with recommendations. A physician response was not documented. A note dated 12/5/23 at 15:58 labeled Pharmacy indicated a late entry was made for a monthly pharmacist medication regimen review with recommendations. A note labeled Order Note on 12/9/23 at 01:31 documented received fax back related to dietician FYI of weight loss and blood sugar control and many med changes as well. Dr. response: acknowledged. An interview with Staff A, LPN at 12:49 PM on 1/17/24 revealed DRR and Gradual Dose Reduction (GDR) reviews were initiated by the pharmacy every month. A form was sent to the facility, reviewed by staff, and then sent to the provider for review and comments. An interview with the DON on 4/18/24 at 10:11 AM confirmed she and the ADON signed the initial admission documents and were aware the resident was prescribed psychotropic medications. She further stated nursing was responsible for communicating with the pharmacist and provider. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy titled Pharmacy - Consulting, reviewed by the facility on 2/1/24, indicated Medication Regimen Reviews were conducted within one week of new admission, upon starting an antibiotic, and monthly.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972 Based on observation, policy review, and staff interview, the facility failed to ensure they were not serving expired food items to reduce the risk of contamination and food-borne illness. The facility reported a census of 50 residents. Findings include: On [DATE] at 9:16 AM, the initial tour of the facility kitchen with the Dining Services Director (DSM), revealed the following: a. 5 unopened boxes of fudge cream icing mix with an expiration date of [DATE] b. 2 unopened boxes of cinnamon streusel topping mix with an expiration date of [DATE] c. 1 unopened box of cinnamon streusel topping mix with an expiration date of [DATE] d. 10 cans of evaporated milk with an expiration date of [DATE] e. 1 opened box of grape nuts cereal with a resident's name on it and an expiration date of [DATE] f. 1 unopened box of grape nuts cereal with an expiration date of [DATE] g. 12 unopened quart containers of half and half with an expiration date of [DATE] h. 2 unopened containers of whipping cream with an expiration date of [DATE] i. 1 unopened container and 1 opened container of whipping cream with expiration date of [DATE] In an interview on [DATE] at 2:35 PM, the DSM stated it was the expectation that staff check for expired food items each day as they go, with new delivery orders, and at a minimum of twice a week. The facility provided policy titled Date Marking/Leftovers/Discarding Food, last reviewed on [DATE] lacked direction for monitoring for expired food items.