STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165606	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perry Lutheran Home	2323 East Willis Avenue Perry, IA 50220

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004 Based on clinical record review, policy review and resident and staff interviews the facility failed to ensure that all residents are treated with dignity and respect, and free from abuse during resident care tasks for 1 of 4 residents reviewed (Resident #7). The facility reported a census of 62 residents. Findings include: The Minimum Data Set (MDS) assessment tool, dated 2/17/24, listed diagnoses for Resident #7 included cerebral palsy, hemiplegia (paralysis or weakness on one side of body), seizure disorder, anxiety disorder and intellectual disabilities The assessment indicated the resident required substantial assistance for upper and lower body dressing, personal hygiene, and dependent for transfers. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score of 8 out of 15, indicating a moderate cognitive impairment. The Care Pan updated on 6/20/23 included a focus area regarding Resident #7 becoming frustrated with situations in the environment that he could not control. Interventions included: offering reassurance, and allowing opportunities to express his feelings and concerns. The Care Plan also included a focus area for assistance with Activities of Daily Living and impaired balance. Interventions included: two staff assisting with a mechanical lift for transfers. According to a document titled: Allegation of Abuse Investigation, dated 4/22/24, it was reported to the Director of Nursing (DON) by Staff A, Certified Nursing Assistant (CNA), that on 4/22/24, Staff B, CAN had been rough when caring for Resident #7. The resident was having difficulty using the mechanical sit to stand lift, and needed to rest. When the resident asked to try again, Staff B yelled at him f*** no and that she had things to do. Staff A reported that Staff B used more force than necessary when assisting him into bed. The investigation included interviews with staff and residents and is had been mentioned that Staff B sometimes would rush through cares and would be rough. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 9:40 AM, Staff A, CNA stated on 4/22/24, she assisted Staff B, CNA to put Resident #7 to bed for the night. When they transferred him with the mechanical lift, the resident said that he needed to sit down so they lowered him to sit on the bed. When the resident asked if they could try it again, Staff B got in his face and said f*** no The resident did not say anything but he had a nervous laugh. They unhooked him from the lift and with Staff A at the top half the body, and Staff B at the feet, they guided him to the laying position and Staff B held onto his legs and threw him into bed. The resident then said whoa! and nervously laughed again. Staff B then said I got shit to do On 5/13/24 at 11:10 AM, Staff B, CNA denied that she was rough with the resident or swore at him. She denied having any disciplinary reports in her personal file. On 5/14/24 at 10:01 AM, Staff C, Registered Nurse (RN) said that she was the nurse on duty on the evening of 4/22/24. She had been busy with passing the evening medications and was not aware of an incident between the CNA's and Resident #7. Staff C said that Staff B had been frustrated that day because she worked a 12-hour shift. She was tired and anxious to get home. On 5/15/24 at 8:45 AM, Resident #8 (MDS dated [DATE] showed BIMS score of 15) said that she knew Staff B and she was nice to her. The resident said that Staff B didn't yell at her or get upset with her but there were times that she heard her get upset with other residents. On 5/15/24 at 8:50 AM, Resident #3 (MDS dated [DATE] showed a BIMS score of 14) said that she remembered Staff B because she would kind of yell and get in a hurry. She said that if the staff member was in a bad mood, she would yank her shoes off forcefully and throw them across the room. It was too bad, because otherwise she could be a decent person. On 5/15/24 at 8:01 AM, the Director of Nursing (DON) said that Staff B was suspended while they investigated the allegations of abuse, and later they did terminate her. They terminated her because they felt that there were discrepancies in the recall of the events on 4/22/24, and they did have reports that she would get frustrated and displayed that frustration in front of residents. A facility policy titled: Abuse Prevention, Identification, Investigation and Reporting Policy, dated January 3, 2024 showed that personal degradation included willful acts or statements intended to shame, degrade, humiliate or otherwise harm the dependent audit's personal dignity.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 46875 Based on clinical record review, staff interviews and facility policy review the facility failed to provide a bed hold upon hospitalization for 2 of 2 residents reviewed (Resident #38, #114). The facility reported a census of 62 residents. Findings include: 1. The Minimum Data Set (MDS) assessemnt,dated 6/24/23, for Resident #38 identified a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severely impaired cognition. The diagnoses for Resident #38 included coronary artery disease, hypertension (high blood pressure), diabetes mellitus, and Alzheimer's disease. The Clinical Census revealed the resident discharged to the hospital on 9/13/23. A Nurses Note dated 9/13/23 at 9:43 PM revealed Resident #38 was admitted to the hospital for a fractured hip. The clinical record lacked documentation the facility provided a bed hold notice to Resident #38 and/or the residents respresentative upon discharge to the hospital. On 5/14/24 at 2:52 PM, the Director of Nursing (DON) reported she could not locate a bed hold form for Resident #38. She stated it was an expectation for the nurses to complete the bed hold when sending someone to the hospital. 2. The MDS assessment, dated 12/2/23, for Resident #114 identified a BIMS score of 15 out of 15, inicating intake cognition. The MDS included diagnoses of coronary artery disease, hypertension (high blood pressure), osteoporosis, seizure disorder, chronic obstructive pulmonary disease, and other fractures. The Clinical Census revealed Resident #114 was discharged to the hospital on 12/15/23. A Nurses Note, dated 12/16/23 at 12:40 AM, revealed Resident #114 was admitted to the hospital for a fractured left ankle. The Clinical record lacked documentation the facility provided a bed hold notice to Resident #114 and/or Resident #114's representative upon discharge to the hospital. On 5/16/24 at 9:25 AM, the DON acknowledged and verified a bed hold notice was not completed for Resident #114. A facility policy, dated 2024, titled Bed Hold Policy Statement: Prior to and upon transfer of a resident to a hospital or the resident goes on therapeutic leave, the facility will provide written notice to the resident and/or representative of the bed-hold policy. (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	The policy implementation documented at the time of the transfer, or in case of emergency, within 24 hours resident and/or representative will be notified of bed hold notice. Initial notification may be via phone and followed up with written form. The written bed hold notice will specify: *The duration of the bed-hold policy during which the resident is permitted to return and resume residence in the facility. *The reserved bed payment policy. The rate for holding a bed will be determined by the resident ' s payer source. *The facility policy regarding bed-hold periods regarding permitting residents to return to the facility. The policy further documented that the facility agreed to hold the bed of any resident upon the return of a signed bed hold agreement or the verbal confirmation obtained by the facility. Each time a resident goes out of the building; a new bed hold agreement must be obtained.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observations, interviews and record review the facility failed to ensure comfortable positioning, and securement of the safety straps when using a mechanical lift device for 2 of 3 residents reviewed (Resident #22, Resident #30). The facility reported a census of 62 residents. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 4/6/24, listed diagnoses for Resident #22 included cerebrovascular accident (stroke), aphasia (impaired communication), and hemiplegia right side dominant (paralysis/impaired function of right side). The MDS assessed the resident required substantial assistance for mobility and all transfers. A Brief Interview for Mental Status (BIMS) could not be completed due to the resident being rarely/never understood. The Care Plan updated on 4/24/24 included a focus area Activities of Daily Living for Resident #22. Interventions included the use of an EZ Stand (type of mechanical lift) of two staff for transfers. In an observation on 5/13/24 at 12:05 PM, Resident #22 could be heard from the hallway making loud utterances. Staff F, Certified Nurse Aide (CNA), and Staff G, CNA entered the room to find the resident leaning to the right in his wheel chair. They prepared to transfer him with the use of the EZ Stand. Staff F assisted the resident to sit forward in the wheel chair and as she attempted to apply the sling behind his back, he hollered out in pain. The resident's right arm was stuck between the handle of the wheel chair and the padded cushion that extended up the side of the wheel chair. Staff F helped the resident free his arm. The staff proceeded to hook the sling up to the lift and placed his feet on the platform. The staff did not lock the wheels of the lift. The resident rocked back and forth with his feet, causing the lift to move as the staff raised the device. The resident was not holding onto the handles and grabbed the front of the machine as staff began to change his incontinence brief. While in a standing position, Staff G strapped the residents legs to the lift, and failed to tighten the buckle around his torso. 2) According to the MDS, dated [DATE], listed diagnosis for Resident #30 included diagnoses of displaced intertrochanteric fracture of left femur, pain in left shoulder, muscle weakness and Chronic Obstructive Pulmonary Disease (COPD). The MDS assessed the resident as dependent on staff for all transfers, and use of the toilet. The resident had a BIMS score of 4 out of 15, indicating severely impaired cognition. Resident #30's Care Plan, updated on 2/7/24, included a focus area to address the need for assistance with Activities of Daily Living (ADL's). Interventions included the assistance of two staff to use the toilet, and the assistance of 2 staff for transfers using the EZ Stand. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 5/13/24 at 12:23 PM, Staff G, CNA and Staff H , CAN transferred Resident #30 with the use of the EZ Stand. They situated the sling behind the resident's back while she was in the wheel chair and attached it to the lift. The resident held onto the padded handles of the lift, but her right arm was under the sling. When the resident was raised up to the standing position, staff failed to tighten the buckle around her torso. They moved her to the toilet and when she was finished, the sling on the right side was adjust to be under her arm. As they raised her off the toilet and she was in the standing position, they provided peri care, and failed to tighten the buckle. On 5/15/24 at 1:50 PM the Director of Nursing (DON) said that they have a skill fair where they teach the staff how to properly use the mechanical lift. She provided and audit checklist titled: Mechanical Lift Transfer Audit. The document lacked direction to tighten the waist belt once the resident was standing on the EZ Stand. According to the EZ Way Smart Stand Operators Instructions dated 7/30/18, staff were directed to position the patients arms on the outside of the harness and have them place their hands on the padded handles. As the patient was being raised, simultaneously tighten the safety strap buckled around their torso.