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	11/07/2024

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 0684

Level of Harm - 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 25858

Based on clinical record review, staff interview, and facility policy/procedure review at the time of the investigation, the facility failed to provide needed services in accordance with professional standards for one of three residents reviewed by not sending a resident to the nearest emergency room when their was a change in their assessment for which resulted in the resident being admitted to the hospital with hypoxemia, bronchopneumonia and dehydration. (Resident #2). The facility identified a census of 59 residents.

Findings include:

1. A Admission Minimum Data Set (MDS) completed for Resident #2 with an assessment reference date of 8/5/24, documented diagnosis for which included hypertension, non-Alzheimer dementia, anxiety, depression, asthma and chronic obstructive pulmonary disease (COPD). The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe impaired cognitive decisions and no acute onset of mental changes. The resident required substantial assistance to maximal assistance for activity of daily living and was independent with ambulation with a walker.

The Careplan with a focus area initiated 8/12/24, I have a diagnosis of Chronic Obstructive Pulmonary Disease

and am at risk for shortness of breath and respiratory infections. Interventions include:

*Allow for rest periods between tasks as needed.

*Give bronchodilator as ordered. Document any side effects and effectiveness. Document adverse effects trembling, headaches, dry mouth, palpitations, muscle cramps, cough, nausea and vomiting, diarrhea.

*Nebulizer Therapy: Change Tubing Weekly and PRN

*Observe daily for signs of respiratory infections or distress, adventitious lung sounds, shortness of breath, elevated temperature and notify physician as indicated.

*Observe for signs/symptoms of hypertension such as headache, visual changes, mental status changes, slurred speech, decreased alertness. report to physician as indicated.

(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 0684 Level of Harm - Actual harm Residents Affected - Few	*10/11/24: resident was sent to emergency room and admitted for bronchitis related to COPD The Progress Notes documented on the following dates and times: *10/9/2024 at 1:02 p.m. Nurses Note Text: Resident is on follow up for being lowered to the floor. Resident short of breath this morning. Walked with staff and allowed this nurse to administer suppository for constipation. Effective. Resident walked without difficulty using walker and used inhaler. Appears more comfortable sitting upright. *10/9/2024 at 4:25 p.m., Nurses Note Text: Called to unit by staff, resident was sitting at a table in the dining area, stood up and moved with out his walker. Reached for the hand rail and lost his balance, falling to his left side. Hitting his head on the shower room door. Staff assist to standing, Sat resident in a straight chair. Neuro checks initiated. Neurological continue until resident became combative. Will reapproach . *10/9/2024 at 5:38 p.m., Nurses Note Text: Sitting at table with peers for supper, as needed Tylenol given to promote comfort as he stated his legs ache. Neurological continue as he will allow. *10/10/2024 at 11:36 p.m., Nurses Note Text: follow up on fall 10/09/24. No latent injuries noted. Ambulating with a fairly steady gait with front wheeled walker and assistance of one. *10/11/2024 at 3:21 p.m., Nurses Note Text: Staff called this nurse to assess resident with concern that resident was pale and slurring. Not at his regular baseline. Resident was very sleepy. Resident was slurring his words and wasn't cooperating with instructions. Resident woke up and ambulated using his walker to the dining room and had very little appetite. Resident remained alert the rest of this morning shift. Orthostatic Blood pressures are low. Completed twice this shift. 101/59 laying, Standing 99/68, Sitting 100/56. Resident denies pain. Slightly aggressive with cares. *10/11/2024 at 9:15 p.m., Nurses Note Text: Resident is on fall follow up. Observed resident in unit to be sitting at the table. Staff reports he did not eat this evening. Resident awake, mumbling, looking down at floor. Staff reported they attempted to get resident to stand and walk down the hallway to bed but he would not stand. Registered Nurse (RN) assisted staff to stand resident at this time and he continued to not want to put feet down and stand up. He (continued on next page)

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

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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 - Actual harm Residents Affected - Few	eventually did and had one foot on top of the other while in upright position. Staff straightened his feet out and he began to walk but it was very staggered type of walking. Resident holding on to walker and would pull brakes up making it difficult to move forward. Resident needed numerous instructions to unlock brakes and keep walking. At point halfway down the hall, resident stopped and refused to go any further. He sank down to his knees, staff unable to hold him up. He was lowered to the floor on his knees without incident. Additional staff called to assist resident back to standing. He stood with maximum assist of 3 staff but would not walk. Resident put on seat of his walker and rolled to his room. Resident brought to side of his bed at which time he laid himself back with feet outstretched and became minimally unresponsive. Resident transferred to his bed. Residents eyes were open and staring. Pupils small and slowly reactive. He was not moving eyes or tracking to sound of staff voice. He would not grip hands and was not moving his extremities. He did not respond to verbal or tactile stimuli. Heart rate continued to erratic up into 130s. Blood Pressure initially unable to obtain, then finally able to get 68/48. Recheck 100/68. Oxygen placed at 2.5 liters and pulse ox came up to about 83-85%. Skin color to face grayish. Spoke with Dr. on call for who stated to send resident to ER. EMS called. Report called to ER. While other staff sat with resident while this nurse made phone calls etc, staff reported resident would intermittently yell out like he was in pain. Resident left facility. Resident was more alert at time of transfer but not at baseline. *10/12/2024 at 1:03 a.m., Nurses Note Text: Received call from nurse at hospital. Resident is being admitted at least through the weekend. Resident has bronchitis related to COPD exacerbation, hypoxemia, and dehydration. CT scan was negative for a brain bleed. He was given a half liter of fluid and perked up, and his color improved. He will be receiving antibiotics. *10/14/2024 at 8:39 a.m., Nurses Note Text: Received phone call from hospital that resident will be discharging today. Report given to this nurse and is as followed: Has been standing and pivoting, using nebs, antibiotic, and incentive spirometer for pneumonia, vitals have been stable, has had thick productive cough, had bowel movement yesterday (10-13). No combativeness in hospital. *10/14/2024 at 11:30 a.m., Nurses Note Text: Resident returned to facility via wheelchair this morning. He was discharged from the hospital. Resident was hospitalized secondary to mental status changes and profound weakness. Resident admitted to the hospital for acute COPD exacerbation and bronchopneumonia. He has poor dentition, pupils equal and reactive. He does have diminished breath sounds bilateral lower lobes. Heart rate regular, abdomen is soft and non-tender. Bowel Sounds are positive all 4 quadrants. He is slow to respond, not making much sense when speaking. He does answer easy yes/no questions appropriately. The Neurological Assessment Flow Sheet dated 10/9/24, documented: every 15 minutes times 4, every 30 minutes times 4, every 1 hour times 4 and every shift times 24 hours. 10/9/24 at 3:25 p.m., resident alert, with equal pupil response and hand grips, move all extremities and . appropriate response to pain (continued on next page)

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

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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 - Actual harm Residents Affected - Few	10/9/24 at 3:40 p.m., resident alert, with equal pupil response and hand grips, move all extremities and appropriate response to pain. 10/9/24 at 3:55 p.m., resident alert, with equal pupil response and hand grips, move all extremities and appropriate response to pain. 10/9/24 at 4:10 p.m., resident alert, with equal pupil response and hand grips, move all extremities and appropriate response to pain. 10/9/24 at 4:40 p.m., resident alert, with equal pupil response and hand grips, move all extremities and appropriate response to pain. 10/9/24 at 5:10 p.m., resident drowsy, sluggish pupil response, unable to follow commands for hand grasps and movement of extremities, and absent with pain response. 10/9/24 at 5:40 p.m., resident drowsy, sluggish pupil response, unable to follow commands for hand grasps and movement of extremities, and absent with pain response. 10/9/24 at 6:10 p.m., resident drowsy, sluggish pupil response, unable to follow commands for hand grasps and movement of extremities, and absent with pain response. 10/9/24 at 7:10 p.m., resident drowsy, equal pupil response, unable to follow commands for hand grasps and movement of extremities, and absent with pain response. 10/9/24 at 8:10 p.m., resident drowsy, equal pupil response, unable to follow commands for hand grasps and movement of extremities, and absent with pain response. 10/9/24 at 9:10 p.m., resident drowsy, equal pupil response, unable to follow commands for hand grasps and movement of extremities, and absent with pain response. 10/9/24 at 10:10 p.m., resident drowsy, equal pupil response, unable to follow commands for hand grasps and movement of extremities, and absent with pain response. 10/10/24, 6:00 a.m.,- 2:00 p.m., chart lacked documentation of neurological assessment being completed. 10/10/24, 2:00 p.m.,-10:00 p.m., resident drowsy, equal pupil response, unable to follow commands for hand grasps and movement of extremities, and absent with pain response. 10/10/24, 10:00 p.m.,-6:00 a.m., resident drowsy, equal pupil response, unable to follow commands for hand grasps and movement of extremities, and absent with pain response. The Nursing Facility to Hospital Transfer Form dated 10/11/24 with no time, documented that the reason for transfer is due to change in mental status, status post fall on 10/9/24. Mental status as confused and forgetful. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The County Hospital History and Physical dated 10/11/24 at 11:50 p.m., documented the chief complaint for this resident is altered mental status, profound weakness. The [AGE] year old male that lives at a local memory unit in a skilled nursing facility. fell 2 days ago with what appears to be a minor head injury but does take aspirin regularly. Today he was found to be weak, requiring assistance for ambulation where typically he does not. This evening he became increasingly more confused and less responsive, but because of his decreased responsiveness he was brought to the emergency room . Found to be with an oxygen saturation of 77% on room air. I later spoke to his wife and she says he has not been eating or drinking for several days now. He can ambulate with standby assistance but has not been able to do that for several days. There has been a cough. Physical Assessment: Oral membranes are dry. His lungs are with decreased breath sounds and rhonchorous breath sounds as well. He is easily agitated with attempts at movement or body position change. Plan: Patient is clinically dehydrated. Poor oral intake for several days of both food and water likely contributing to hypotension, increase in creatinine and hypernatremia. Will admit for COPD exacerbation secondary to acute bronchitis and possible bronchopneumonia, secondary hypoxemia as well as dehydration with hypernatremia. Interview on 11/7/24 at 8:10 a.m., the facility Director of Nursing (DON) confirmed and verified that the facility staff are expected to notify the physician of any changes in a residents neurological assessment and to follow the facility policy and procedure, the director of nursing also confirmed with the physician that the expectation of the staff are to notify the physician of any changes in a resident neurological assessment. The Neurological Assessment Policy and Procedure dated 2024, documented that the purpose of this procedure is to provide guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition. Neurological assessments are indicated: 1) Upon physician order; 2) Following an unwitnessed fall; 3) Following a fall or other accident/injury involving head trauma; or 4) When indicated by resident's condition. 5) Any change in vital signs or /neurological status in a previously stable resident should be reported to the physician immediately. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Reporting 1) Notify the physician of any change in a resident's neurological status. 2) Notify the supervisor if the resident refuses the procedure. 3) Report other information in accordance with facility policy and professional standards of practice.