STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165606	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025

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 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** 49056 Based on clinical record review, staff interviews, facility record review, and facility policy review the facility failed to implement specific fall interventions in a timely manner after 3 falls for 1 of 1 residents reviewed (Residents #3). The facility reported a total census of 60 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented diagnoses of non-Alzheimer's Dementia, anxiety, depression and hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 11, indicating moderate impairment cognition. Review of MDS dated [DATE] revealed Resident #3 was substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds the trunk or lungs and provides more than half the effort) with transfers and upper and lower body dressing. Review of the facility reported incident dated 2/14/25 at 7:05 AM revealed Resident #3 was walking with a staff member with her walker to the bathroom when she became weak. Resident #3 was lowered to the floor. Resident #3 assessed for injuries, and none found. The root cause analysis was performed and showed increased weakness which caused Resident #3's knees to buckle, the intervention will be to perform follow up labs to check infection status. The Care Plan has been updated with changes. Review of Resident #3's Care Plan with an initiated date of 2/17/25 revealed the intervention was to perform follow up labs to check infection status. Review of facility Progress Notes revealed lab work was obtained by staff on 2/18/25. Interview on 3/13/25 at 2:05 PM with he ADON and she stated she followed up with the nurse that filled out the incident report for the fall on 2/14/25 at 7:05 AM to encourage staff to utilize extra help if Resident #3 felt weak. The ADON confirmed and verified that this education was not documented. The ADON also confirmed that the lab work completed on 2/18/25 was the intervention for this fall and that no other intervention was put into place. (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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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility reported incident dated 2/14/25 at 11:50 PM revealed Resident #3 was found on the floor lying on her left side, her knees were pulled up partway to her abdomen, resting on left arm and right arm over torso. Resident #3 was lying on top of her grabber, and had regular athletic socks on. Resident #3 was last seen at 11:15 PM. Resident #3 returned four days ago from the hospital due to pneumonia and on an antibiotic. Resident #3 has increased confusion. Resident #3 had no injuries observed at the time of the incident. The root cause analysis was performed and showed increased confusion. The intervention will be to update the physician of Resident #3 not being back to baseline and to follow his recommendations. The facility educated staff to utilize gripper socks during night time care. The Care Plan has been updated with changes. Review of the resident Care Plan with initiated date of 2/17/25 intervention revealed to update the physician regarding Resident #3 not being back to baseline and to follow physician recommendations. The facility failed to add documentation of utilizing the gripper socks with night time cares to the Care Plan. Review of facility Progress Notes on 2/15/25 at 4:02 AM revealed the immediate intervention was to put gripper socks on. Interview on 3/13/25 at 2:05 PM with the ADON and she stated she requested the floor nurse to update the physician on the condition of Resident #3 regarding the increased confusion and falls. The ADON acknowledged that the floor nurse faxed the results of the lab work with a note stating follow up CBC and CMP post hospital with pneumonia. Do you wish any changes, last dose of antibiotic given 2/17/25. The physician responded back with no changes on 2/20/25. The ADON acknowledged that there was not an intervention put into place for this fall. Review of the facility reported incident dated 2/16/25 at 10:45 PM revealed Resident #3 was found on the floor lying almost prone on the floor alongside her bed. Resident #3's right hip was resting on the base of her side table, left leg was lying partly on her right leg and her head was resting on the base of the side table. Resident #3's body was partially wrapped up in the bedding. Resident #3 had on athletic socks. Resident #3 stated I was trying to get out The basement, I was going to fall into the basement. I was hollering for my sister. Resident #3 received two new bruises, no other injuries noted. The immediate interventions were to place gripper socks on and the roll up blankets on the edges of the bed to remind Resident #3 of the mattress borders. The root cause analysis was performed and showed increased confusion, increased weakness, facility will request physical therapy to evaluate and treat orders and also educated staff to put on gripper socks during night time care. Review of resident Care Plan with initiated date of 2/17/25 revealed the intervention was to request physical therapy orders to evaluate and treat. The facility failed to add documentation of utilizing the gripper socks with night time cares to the Care Plan. Review of the facility Progress Notes dated 2/17/25 at 9:57 AM the son requested the bolster mattress be put back on Resident #3's bed. Review of the facility Progress Notes dated 2/21/25 at 9:34 AM the facility requested physical therapy orders and at 12:51 PM received orders for physical therapy. Review of the facility policy dated January 2025 and titled Falls and Fall Risk, Managing revealed: (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. An interview on 3/13/25 at 2:05 PM with the ADON revealed that these falls happened on the weekend and she thinks they have 3 days to review them and put interventions in place. The ADON stated her expectation would be to have nursing implement timely interventions when the ADON is not available and they could put any simple interventions in place.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48886 Based on observation, staff interview and policy review, the facility failed to store and maintain medications in a safe manner. The facility reported a census of 60 residents. Findings include: During an observation on 3/11/25 at 10:54 AM, the medication cart was located in the main hallway by the dining room on the CCDI (Chronic Confusion or Dementing Illness) unit, up against a wall, unlocked. On top of the medication cart was a bubble packet of prescription medication of Olanzapine (an Antipsychotic medication) with 2 pills left in the packet. The cart was left unattended. Approximately 3 minutes later Staff B, Licensed Practical Nurse (LPN), came out of the dining room to the cart. The cart was not observable from the dining room, there is a wall separating the cart from the dining room. Three residents were observed by the medication cart, two of the residents walking independently and one in a wheelchair. The cart was unattended upon arrival to the unit at 10:54 AM, with no nursing staff present, and was unattended for approximately 4 minutes of observation. During an interview on 3/11/25 at 11:05 AM, Staff B stated she does not normally leave the medication cart unlocked and unattended and stated she should never leave medications unattended on the cart. Staff B stated many of the residents on the CCDI unit, including one of them who walked past the medication cart several times, like to take items and carry them with them or into their rooms. Staff B stated one resident routinely takes the computer mouse off of the cart and takes it to her room (a resident who walked past the cart more than once). Staff B stated it is not safe to leave the medication cart unlocked and not safe to leave medications unattended on top of the cart. Staff B stated she was in the dining room attending to another resident. During an interview on 3/11/25 at 1:10 PM, the Administrator stated an expectation the medication cart is locked at all times when unattended and an expectation medications are stored and locked in the medication cart and not left unattended on the medication cart. Review of the facility policy, Medication Administration Procedures, dated January 2025, documented the medication cart is to be kept locked at all times unless in use and within nurse's sight.

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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. 49056 Based on observations, staff interviews, and facility policy reviews the facility failed to ensure food was prepared under sanitary conditions. The facility identified a census of 60 residents. Findings include: Observation on 3/11/25 at 11:25 AM Staff A, Cook, applied gloves after performing hand hygiene. Staff A with gloved hands grabbed the bread sack and untwisted the bread tie, then opened the bread sack and took out 4 pieces of bread and laid them on a sheet of parchment paper. Staff A then grabbed the peanut butter jar with her gloved hands along with the knife, proceeded to spread peanut butter on the bread. Staff A grabbed the bread and put it together to make the sandwich and cut the sandwich with the knife. Staff A placed the 2 sandwiches on a plate with her soiled gloves. Staff A, then took off the gloves and washed her hands Observation on 3/11/25 at 11:30 AM Staff A, applied a glove to her right hand then proceeded to open a baggie that had a hotdog package inside. Staff A reached into the baggie to open the hotdog package, then reached into the hotdog package with her gloved hand and pulled out a hotdog and placed it on a plate. Staff A, then took off the glove and washed her hands. Per the undated facility Policy name Proper Use of Single Use Gloves revealed staff must change disposable gloves between tasks and not wear them continuously. A glove must be limited to one task only- thus the term Single Use. Once a person dons (puts on) the glove(s) and leaves the task to open a refrigerator, oven, box, bag, etc, the glove(s) are contaminated and are to be removed/replaced before returning to handling the ready to eat food item(s) and It is preferred to use a utensil (e.g. tong) instead of gloves when handling ready to eat foods if at all possible. Interview on 3/11/25 at 11:55 AM with the Dietary Manager revealed her expectation would be for all staff to get their supplies ready, wash their hands and use tongs to take out the bread from the bread sack and hotdog's from the package.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40905 Based on observations, clinical record review, staff interview, and policy review, the facility failed to maintain infection control standards by staff not disinfecting a facility multi-resident use glucose machine (device to measure blood sugar) after use, failed to complete hand hygiene between administering medications for 4 of 5 residents, failed to change gloves and sanitize hands during cares and failed to apply personal protective equipment for catheter and incontinent care for 1 of 1 resident (Resident #23) reviewed. The facility reported a census of 60 residents. Findings include: 1. Observation showed on 3/11/25 from 11:10 AM - 12 PM, Staff C, Certified Medication Aide (CMA) administered medications to 4 different residents. Staff A did not wash or sanitize hands before or after administering medications to each of the 4 residents. Facility policy Medication Administration Procedures dated January 2025, revealed to cleanse hands before handling medication and before contact with resident. Interview on 3/12/25 at 4:31 PM, the Assistant Director of Nursing (ADON) stated expectation for staff to complete hand hygiene between residents when administering medication. 2. Observation and interview on 3/12/25 at 7:54 AM, Staff D, CMA completed a resident's blood sugar check with the glucose machine and then placed the glucose machine in the medication cart in an open box of lancets (device to puncture a person's skin for blood) without disinfecting the glucose machine. When asked about disinfecting the glucose machine, Staff D stated the glucose machine is a facility machine which is currently used for 2 other residents on the unit also. Staff D then wiped the glucose machine with an alcohol swab and placed the glucose machine back in the box and stated she always just wipes off the glucose machine with an alcohol swab. Facility policy Finger Stick Glucose Check Protocol, dated 6/2024 revealed if using a community wide glucose machine, disinfect after each use following the manufacturer's guidelines for drying time. Interview on 3/12/25 at 3:09 PM, the ADON stated expectation to disinfect the glucose machine after each use with a disinfecting wipe and the glucose machine must remain wet with the disinfectant for 3 minutes per instructions. 49056 3. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #23 documented diagnosis as peripheral vascular disease (a condition that affects the blood vessels outside the heart and brain), benign prostatic hyperplasia (a non-cancerous condition where the prostate gland grows larger than normal, potentially causing urinary difficulties), hip fracture and depression. The MDS included a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation completed on 3/12/25 at 4:30 PM with Staff E, Certified Nursing Assistant (CNA), the aide failed to apply personal protective equipment per Enhanced Barrier Precautions (EBP) when providing catheter care on Resident #23. Observed the EBP's signage on the door of Resident #23. Interview on 3/12/25 at 4:50 PM with Staff E stated she had started back at the facility around three weeks ago and had been told that it depends when to wear it. Staff E stated she realized she should have worn a gown during the catheter care process. Interview on 3/13/25 at 2:05 PM with the Assistant Director of Nursing (ADON) stated that all staff need to utilize the Enhanced Barrier Precautions when needed. Review of the facility policy named Enhanced Barrier Precautions dated June 24, revealed EBP's are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. EBP's are an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of CDC-targeted MDROs. EBP's should be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: Chronic wounds (include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers) and indwelling medical devices, regardless of MDRO colonization status. (indwelling device examples include central/PICC lines, urinary catheters, feeding tubes and tracheotomies). 4. Observation completed on 3/12/25 at 4:30 PM with Staff E, CNA and Staff F, CNA. Staff E and Staff F performed hand hygiene prior to applying gloves then proceeded to perform pericare on Resident #23. Staff E and Staff F assisted pulling Resident #23's pants down, then proceeded to remove the dirty brief. Staff E with soiled gloves proceeded to utilize washcloths to perform perineal care. Staff E and Staff F rolled Resident #23 to his side then proceeded to utilize washcloths to perform perineal care. Staff E placed a clean brief, rolled Resident #23 to his back and fastened a new brief, then Staff E and Staff F proceeded to pull pants up. Staff F failed to change gloves and perform hand hygiene throughout the process of performing pericare. Interview on 3/12/25 at 4:50 PM with Staff F stated that she should have changed her gloves and performed hand hygiene more frequently than she did. Interview on 3/13/25 at 2:05 PM with the ADON stated that she expected staff to change gloves between cares and to sanitize/wash hands after cares are completed. Review of the facility provided Peri Care Audit revealed: 1. Assemble equipment: peri care items, bags, towel/blanket to cover for privacy. 2. Knock on door before entering. 3. Explain procedure to resident. 4. Provide privacy: i.e. room door/bathroom door, privacy & window curtains. 5. Wash hand & put on gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Remove any badly soiled pads, clothing, linens & place in container/bag per protocol. If pad is not heavily soiled it can be turned on itself to expose dry surface area. 7. If removal of soiled linen occurs, then change gloves. 8. Clean the lower abdomen, anterior thighs and dry, as needed. 9. Place soiled wash cloths on a cloth towel or preferably in a plastic bag. 10. Remove gloves before turning resident to their side, unless using buddy system 11. Wash buttocks and both sides of upper thighs, be sure to dry the skin. 12. Wash anal area, front to back using facility choice of solution and cloths/wipes. 13. Remove gloves, wash hands and roll resident to side onto a clean, dry surface. 14. Wash the opposite hip and dry. Remove gloves. 15. Remove gloves, wash hands and re-apply gloves. a. Apply moisture barrier per facility protocol. Note: must use new gloves if additional barrier must be removed from container for further application. b. Remove gloves and cleanse hands when application is complete. 17. Pick up any soiled equipment used, place in plastic bag to remove to area to clean. 18. Wash hands.