STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165795	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perry Lutheran Homes Eden Acres Campus	3000 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. The MDS of Resident #35 dated 4/1/25 indicated that the resident used corrective lenses and hearing aides. The MDS identified a BIMS score of 10 indicating moderate cognitive impairment. Diagnoses listed on the MDS included cataracts, glaucoma or macular degeneration. The assessment triggered Care Areas for both visual function and communication, with documentation dated 4/8/25 that these would be addressed in the resident's care plan. On 6/23/25 at 3:03 pm, Resident #35 was observed wearing glasses and bilateral hearing aides. She was overheard telling an activity staff member that she was unable to read the activity calendar and requested a larger-print version. A review of Resident #35's Care Plan on 6/23/25 showed that neither vision nor communication concerns were addressed in the Care Plan. On 6/26/25 at 9:34 am, the MDS Coordinator confirmed both vision and communication should have been included in the Care Plan and stated she normally addresses those areas under the Activities of Daily Living (ADLs) Focus Area. She acknowledged their absence and stated she would add both areas. On 6/26/25 at 10:56 am, Resident #35 was observed in her wheelchair approximately three feet from her closet door, where the activity calendar was posted. She stated she could not read it at all due to the small print. She noted in previous months, the calendars were printed in a larger format. The October 2024 RAI 3.0 User's Manual documented the following: For each triggered care area, Column B Care Planning Decision is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The Care Planning Decision column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed. For each triggered care area, indicate the date and location of the CAA documentation in the Location and Date of CAA Documentation column. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation. The facility policy Care Plans, Comprehensive Person-Centered dated 2024 documented the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Point 2: The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. Based on observation, clinical record review, resident and staff interview, the October 2024 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and facility policy review, the facility failed to care plan a high risk medication for 1 of 5 residents reviewed (Res #19). The facility additionally failed to fully develop and personalize a care plan for vision and communication for Resident #35. The facility reported a census of 47 residents. Findings include: 1. Resident #19's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. The MDS identified Resident #19's MDS documented diagnoses of hypertension (high blood pressure), non-Alzheimer's dementia, Parkinson's disease, depression, insomnia and restlessness and agitation. Resident #19's Clinical Physician Orders revealed an order for Lorazepam (antianxiety) 1 mg tablet by mouth every 8 hours as needed for agitation related to restlessness and agitation. The facility received the order on 3/31/25 and the end date for 9/27/25. The Care Plan with an initiated date of 4/9/21 failed to mention the high risk medication, non pharmacological interventions or side effects. The Medication Administration Record for the month of April 2025 revealed Resident #19 received the Lorazepam 13 times. The month of May 2025, Resident #19 received it 2 times and for June 2025 Resident #19 received it 2 times. On 6/26/25 at 11:50 am the MDS Coordinator stated that she was working on the MDS and was going to update the care plan today. She stated that Resident #19 had only taken the medication a couple of times this month. The MDS Coordinator stated that she pulls a report weekly to see when there are new medications to add to the care plan, the MDS Coordinator acknowledged that she missed this medication. On 6/26/25 at 12:11 pm in an interview, the Director of Nursing stated the expectation is to have high risk medications addressed on the care plan when the medication is implemented.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and facility policy review, the facility failed to store frozen food in a clean freezer. The facility reported a census of 47 residents. Findings include: On 6/23/25 at 9:58 AM, a dual-door, upright freezer had condensation in the location where both doors met. A black substance was noted on the top of the bottom freezer door. The freezer contained a bag of frozen cookie dough. On 6/24/25 at 8:20 AM, the condensation and black substance were still noted in the same location on the upright freezer. At 8:24 AM, the Certified Dietary Manager (CDM) stated the freezer should not look like that and needed to be cleaned. A policy titled Infection Prevention & Control Protocol dated 6/2024 included a protocol to reduce the risk of spread of infection by managing food safety.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on the Centers for Medicare & Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (January 1 - March 31, 2025) review and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 47 residents. Findings include: The PBJ Staffing Report for Fiscal Year 2025, Quarter 2, reflected the facility failed to have licensed nursing coverage 24 hours day on seven days of the quarter. The Administrator was notified of this on 6/25/25. She stated she was aware there had been an issue with the time clocks and some of the employee hours were not getting included in the time cards. She stated the facility used a consultant group to submit the PBJ hours to submit the required staffing information to CMS. She stated the consultant group sends an email when issues are noted and she believed the issue was fixed. On 6/25/25 at 1:42 pm, after reviewing the seven days in question, the Administrator stated the facility has a sister facility nearby and Staff A, Registered Nurse (RN) worked at both locations. Staff A had worked all seven of those days. Staff A was present and worked all seven days as scheduled at this facility. However, she accidentally clocked in under the incorrect facility code, which caused the error. Although she was scheduled for and physically worked at this facility, the time clock entry reflected the other facility, due to the code mistake.