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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 11/6/18 for F686 11/16/18 for all others Complaints # 77428-C, # 78495-C and # 78679-C were substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165606	A. BUILDING _____ B. WING _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 1	F 609		

appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

Based on clinical record review, observation and staff interview, the facility failed to report all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours for one of 11 residents reviewed. Resident #7 received three injuries of unknown origin in less than a month. The facility failed to report the injuries of unknown source to the State Agency as required. The facility reported a census of 62 residents.

Findings include:

1. The Minimum Data Set (MDS) with assessment reference date of 10/3/18, assessed Resident #7 with a brief interview for mental status (BIMS) score of "2" (severe cognitive impairment) The resident had no behaviors identified. The resident was independent with bed mobility, transfers and ambulation. She required extensive staff assistance with dressing, toileting and bathing. The resident was frequently incontinent of bowel and bladder. A test for balance during transitions and walking revealed the resident as steady at all times. Resident #7 used a walker for ambulation and entered the facility on 9/26/18.

On 10/22/18 at 10:33 a.m. during tour of the CCDI (chronic confusion and dementing illness) unit, observation revealed a bruise by the

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 resident's right outer eye/eyebrow area. Review of the resident's departmental notes revealed the following: 10/5/18 at 11:44 p.m. staff observed a 3 centimeter (cm.) by 4.2 cm. bruise to the resident's right knee. The resident stated she didn't know where she got it. 10/13/18 at 9:16 p.m. staff documented the resident's left inner hand looked bruised but not red or inflamed. 10/14/18 at 2:29 a.m. staff documented the resident's left hand index finger had 5 intact stitches with a clean dry steri strip over it. The departmental notes contained no other information as to how the resident came to have 5 sutures in her hand. 10/19/18 at 4:10 p.m. staff observed a bruise to the right outer eyebrow forehead area. The resident could not say why the area was there or if there was a bruise. 10/21/18 at 3:59 p.m. the physician was at the facility and removed the resident's sutures from her hand. Resident #7's Incident Reports recorded the following information: 10/5/18 at 9:30 p.m. identified an unwitnessed incident with location identified as: resident room. Staff listed the incident type as fall/no head injury. Staff observed a bruise to the right knee measuring 3 cm. by 4.2 cm. The narrative of the investigation revealed the facility was unable to	F 609		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 3	F 609		

determine the cause of the bruise due to the resident's status as independently ambulatory. On 10/24/18 at 5:30 p.m. the MDS nurse stated the resident did not fall that they knew of.

10/12/18 at 4:31 a.m. identified an unwitnessed incident at an unknown location. Staff listed the injury type as a deep laceration. Staff observed a deep skin tear to the palm of the resident's left hand under her index finger. The area measured 1.5 cm. wide with a depth of 0.2 cm. The narrative of the investigation identified staff investigated the resident's room and area and could not determine causal factors for the injury. The resident transferred to the ER (emergency room) for treatment.

10/19/18 at 4:27 a.m. identified an unwitnessed incident in an unknown location. Staff listed the incident type as a fall with head injury. A nurse observed a bruise to the resident's right outer eyebrow. Staff documented the bruise had an unknown origin and they noted no fall. The report identified that staff reviewed camera footage. On 10/24/18 at 5:30 p.m. Staff A RN (Registered Nurse) stated 4:27 a.m. was the wrong time, it should be 4:27 p.m.

On 10/24/18 at 5:30 p.m. the MDS nurse, Director of Nursing and Staff A stated they did not interview anyone that Resident #7 encountered prior to discovery of the 10/5/18, 10/12/18 and 10/19/18 injuries. At that time, Staff A stated she reviewed camera footage for the 10/19/18 incident and saw nothing unusual.

On 10/25/18 at 11:30 a.m. the MDS nurse stated the video as unavailable for the 10/5/18 incident.

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 4 Review of camera footage for the 10/12/18 4:31 a.m. incident: The footage from 7:30 p.m. until 4:47 a.m. revealed nothing unusual and the resident in her room during the time. She had encounters and/or was observed by five staff during this time. None of them were interviewed regarding what they observed while checking on the resident. Review of camera footage for the 10/19/18 4:30 p.m. incident: The footage from 12 p.m. to 4:28 p.m. revealed Resident #7 was very active during this time with no obvious rationale for the bruise by the right outer eye/eyebrow. From 3:44 p.m. to 4:15 p.m. the resident was on the patio with a visitor. When asked if the facility spoke with the visitor to see if anything occurred on the patio, Staff A stated she didn't know the resident went to the patio. She stated she viewed the camera footage but did not see that when she viewed it. Observation on 10/24/18 at 4:50 p.m. showed the resident walking independently with a walker. When asked about the bruise by her eye the stated she had "a piece taken off". When asked about hurting her hand, the resident denied it. The facility's Adult Abuse and Reporting policy and procedure, dated 11/16, identified the facility would ensure all injuries of unknown origin would be thoroughly investigated and reported immediately to the Administrator and other officials in accordance with State law through established procedures (including the State survey and certification agency).	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 5 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interviews and facility policy review, the facility failed thoroughly investigate three injuries of unknown origin for one of 11 residents reviewed (Resident #7). The facility reported a census of 62 residents. Findings include: 1. The Minimum Data Set (MDS) with assessment reference date of 10/3/18, assessed Resident #7 with a brief interview for mental status (BIMS) score of "2" (severe cognitive impairment) The resident had no behaviors identified. The resident was independent with bed mobility, transfers and ambulation. She required extensive staff assistance with dressing, toileting and bathing. The resident was frequently incontinent of bowel and bladder. A test for	F 610		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 6 balance during transitions and walking revealed the resident as steady at all times. Resident #7 used a walker for ambulation and entered the facility on 9/26/18. On 10/22/18 at 10:33 a.m. during tour of the CCDI (chronic confusion and dementing illness) unit, observation revealed a bruise by the resident's right outer eye/eyebrow area. Review of the resident's departmental notes revealed the following: 10/5/18 at 11:44 p.m. staff observed a 3 centimeter (cm.) by 4.2 cm. bruise to the resident's right knee. The resident stated she didn't know where she got it. 10/13/18 at 9:16 p.m. staff documented the resident's left inner hand looked bruised but not red or inflamed. 10/14/18 at 2:29 a.m. staff documented the resident's left hand index finger had 5 intact stitches with a clean dry steri strip over it. The departmental notes contained no other information as to how the resident came to have 5 sutures in her hand. 10/19/18 at 4:10 p.m. staff observed a bruise to the right outer eyebrow forehead area. The resident could not say why the area was there or if there was a bruise. 10/21/18 at 3:59 p.m. the physician was at the facility and removed the resident's sutures from her hand. Resident #7's Incident Reports recorded the	F 610		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 7 following information: 10/5/18 at 9:30 p.m. identified an unwitnessed incident with location identified as: resident room. Staff listed the incident type as fall/no head injury. Staff observed a bruise to the right knee measuring 3 cm. by 4.2 cm. The narrative of the investigation revealed the facility was unable to determine the cause of the bruise due to the resident's status as independently ambulatory. On 10/24/18 at 5:30 p.m. the MDS nurse stated the resident did not fall that they knew of. 10/12/18 at 4:31 a.m. identified an unwitnessed incident at an unknown location. Staff listed the injury type as a deep laceration. Staff observed a deep skin tear to the palm of the resident's left hand under her index finger. The area measured 1.5 cm. wide with a depth of 0.2 cm. The narrative of the investigation identified staff investigated the resident's room and area and could not determine causal factors for the injury. The resident transferred to the ER (emergency room) for treatment. An emergency department record dated 10/12/18 revealed the resident was at the ER at 9:33 a.m. for a hand laceration. The note identified the cause as unknown. The laceration involved the palm of the left hand or the left metatarsal head. There was extensive bruising proximal to the area which suggested possible fracture. The resident moved her fingers without difficulty. The left distal metacarpal had swollen and contained a 2 centimeter arc shaped laceration involving the left hand over the distal 2nd metatarsal head. Proximal to that showed extensive bruising. It was mildly tender. The laceration was relatively superficial but deep enough to require suture	F 610		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 8	F 610		

placement and emergency staff placed five sutures. A radiology report dated 10/12/18 at 11:20 a.m. did not identify acute fracture or dislocation.

10/19/18 at 4:27 a.m. identified an unwitnessed incident in an unknown location. Staff listed the incident type as a fall with head injury. A nurse observed a bruise to the resident's right outer eyebrow. Staff documented the bruise had an unknown origin and they noted no fall. The report identified that staff reviewed camera footage. On 10/24/18 at 5:30 p.m. Staff A RN (Registered Nurse) stated 4:27 a.m. was the wrong time, it should be 4:27 p.m.

On 10/24/18 at 5:30 p.m. the MDS nurse, Director of Nursing and Staff A identified they did not interview anyone that Resident #7 encountered prior to discovery of the 10/5/18, 10/12/18 and 10/19/18 injuries. At that time, Staff A stated she reviewed camera footage for the 10/19/18 incident and saw nothing unusual.

On 10/25/18 at 11:30 a.m. the MDS nurse stated the video was not available for the 10/5/18 incident.

Review of camera footage for the 10/12/18 4:31 a.m. incident: The footage from 7:30 p.m. until 4:47 a.m. revealed nothing unusual and the resident in her room during the time. She had encounters and/or was observed by five staff during this time. None of them were interviewed regarding what they observed while checking on the resident.

Review of camera footage for the 10/19/18 4:30 p.m. incident: The footage from 12 p.m. to 4:28

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 9 p.m. revealed Resident #7 was very active during this time with no obvious rationale for the bruise by the right outer eye/eyebrow. From 3:44 p.m. to 4:15 p.m. the resident was on the patio with a visitor. When asked if the facility spoke with the visitor to see if anything occurred on the patio, Staff A stated she didn't know the resident went to the patio. She stated she viewed the camera footage but did not see that when she viewed it. Observation on 10/24/18 at 4:50 p.m. showed the resident walking independently with a walker. When asked about the bruise by her eye the stated she had "a piece taken off". When asked about hurting her hand, the resident denied it. The facility's Adult Abuse and Reporting policy and procedure, dated 11/16, identified the facility would ensure all injuries of unknown origin would be thoroughly investigated. Prior to leaving the facility on 10/30/18, facility staff provided a new investigation form for investigating injuries of unknown origin.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 10 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure a care plan listed the accurate transfer status for one of 11 residents reviewed (Resident #2). The facility reported a census of 62 residents. Findings include:	F 656		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 11 1. A Minimum Data Set (MDS) with assessment reference date of 7/6/18 assessed Resident #2 with a brief interview for mental status (BIMS) score of 15, indicating no cognitive impairment. The resident independently transferred and used the toilet. Resident #2 had two or more falls without injury since the prior assessment. Physical therapy (PT) discharge notes dated 6/12/18 recorded the resident met the goal of transferring with SBA (standby assistance)/supervision. During interview on 10/24/18 at 3:20 p.m. the Physical Therapist confirmed the resident should have standby assistance for transfers. The care plan with problem onset date of 2/7/18 and a goal date of 10/11/18 identified the resident as independent with transfers. Departmental notes dated 7/6/18 at 7:50 a.m. revealed the resident fell when she attempted to transfer herself independently to the toilet with no injury noted.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, the facility failed to provide services that met professional standards of	F 658		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 12 quality for one of 11 residents reviewed (Resident #5). The facility reported a census of 62 residents. Findings include: 1. The Minimum Data Set (MDS) assessment with a reference date of 8/21/18 assessed Resident #5 with a brief interview for mental status (BIMS) score of 2, indicating severe cognitive impairment. The resident required extensive staff assistance with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified the resident at risk for pressure sores and there were no sores present at the time of the MDS assessment. A telephone order dated 10/17/18 identified the resident with a left heel necrotic diabetic ulceration. The order instructed to apply Betadine (antiseptic) and foam every other day until the ulceration improved. The order also directed staff to maintain a bunny boot with darker blue material against the sole of the left foot to better offload. Observation on 10/23/18 at 1:50 p.m. revealed the resident in bed for a treatment and no dressing on the heel when staff removed the bunny boot. When asked about the lack of dressing to the resident's heel, Staff A RN (registered nurse) and Staff B RN stated the resident had a shower that morning. After the treatment Staff C CMA stated the resident received a shower yesterday, not today. During interview on 10/24/18 at 8:57 a.m. Staff C CMA stated she performed the resident's treatment yesterday after her bath and applied	F 658		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 13 the new dressing. When asked why she did not initial she performed the treatment/dressing change on the Treatment Administration Record (TAR), Staff C stated she did not see a place to document an as needed treatment. A CMA job description contained no information the facility trained CMAs to perform treatments and dressing changes for facility residents. During interview on 10/24/18 at 5:30 p.m. the Administrator stated CMAs are not allowed to perform treatments and dressing changes.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, the facility failed to provide assistance to use the toilet or drink fluids for two of 11 residents reviewed (Residents #4 and # 5). The facility reported a census of 62 residents. Findings include: 1. A Minimum Data Set (MDS) assessment with a reference date of 9/15/18 assessed Resident # 4 with memory problems and moderately impaired decision making skills. The resident required the assistance of staff with bed mobility, transfers, eating, dressing, toileting, personal hygiene and bathing. The MDS identified the resident with a Stage 2 pressure sore to the upper left buttock	F 677		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 14 area. a. The resident's care plan dated 1/22/18 directed staff to assist her to use the toilet before and after meals and at bedtime. Observation on 10/24/18 at 12:02 p.m. revealed the resident in the recliner without pressure reduction. The resident remained in the recliner until 1:30 p.m. when she attempted to get out of the recliner per self (1.5 hours without pressure reduction). Staff then transferred the resident to the wheelchair. At 2:20 p.m. the resident sat in a recliner and observation revealed a urine odor. At that time, the surveyor asked Staff C CMA (certified medication aide) and Staff D CNA (certified nurse aide) if they took the resident to the bathroom or checked her that day. Staff C and Staff D said no. On 10/25/18, review of the camera footage for 10/24/18 showed staff took Resident #4 to the toilet at 9:27 a.m. and then not again until 2:41 p.m., after the surveyor questioned toileting assistance (5 hours). On 10/24/18 at 3 p.m. Staff D stated the resident was incontinent when they helped her to the toilet at 2:41 p.m. b. Resident #4's care plan dated 1/22/18 directed staff to encourage her fluid consumption due to a history of urinary tract infections. Observation on 10/22/18 at 12:35 p.m. showed Staff D CNA (certified nurse aide) and Staff E CNA assist the resident to bed. Staff padded the bed, placed a gait belt around the resident and assisted her in bed. They placed her feet under a pillow and covered her up. They left the room without offering the resident liquids. There was no	F 677		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 15 water pitcher in the room. Observation showed on 10/23/18 at 12:35 p.m. two staff transferred Resident #4 into the recliner without offering fluids. On the same date at 2:27 p.m. observation showed staff lay the resident in bed to receive wound care. Staff did not offer the resident liquids before laying her down or leaving the room after wound care. There was no water pitcher in the room. On 10/30/18 at 8:55 a.m. the Administrator stated residents do not have water pitchers in the rooms because the residents on thickened liquids will go in rooms and drink the thin water. The Administrator stated staff should offer liquids when they give care. On 10/30/18 at 9 a.m. Staff C stated there is a water pitcher on the medication cart and staff also offer it from the tap. 2. The MDS assessment dated 8/21/18 assessed Resident #5 with a brief interview for mental status (BIMS) score of 2, indicating severe cognitive impairment. The resident required extensive staff assistance with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified the resident at risk for pressure sores and there were no sores present at the time of the MDS assessment. The care plan dated 5/16/18 directed staff to assist the resident with toilet use before and after meals and at bedtime. Observation showed on 10/23/18 at 1:35 p.m. Staff D CNA and Staff F CNA lay the resident in	F 677		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 16 bed to receive a treatment to the pressure ulcer on the heel. Staff did not assist her to the toilet or check and change the resident. After the resident received treatment to the heel, when the surveyor asked Staff D CNA about not toileting or checking and changing the resident. Staff D stated she was just told to lay the resident down so that's all she did.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and family member interview, the facility failed to complete timely assessment after a change in condition for one of 11 residents reviewed (Resident #4). The facility reported a census of 62 residents. Findings include: 1. A Minimum Data Set (MDS) assessment with a reference date of 9/15/18 assessed Resident # 4 with memory problems and moderately impaired decision making skills. The resident required extensive staff assistance with bed mobility, transfers, dressing, toilet use, personal hygiene and bathing.	F 684		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17 Observation on 10/22/18 at 12:35 p.m. revealed the resident with scattered red raised bumps on the back of the neck and upper shoulders, right torso and right forearm. At that time, the resident's daughter stated the red areas were present on 10/21/18 Review of the resident's Departmental notes did not identify any documentation of the red areas until a late entry 10/23/18 at 9:39 a.m. that identified a red area to the resident's right side. Departmental notes dated 10/24/18 at 1:53 p.m. contained an assessment of the right forearm. The notes recorded the resident had three areas that were pink/round and raised. They measured 1 by 1 inch, 1.2 by 1 inch and 0.8 by 1 inch. Departmental notes dated 10/24/18 at 1:14 p.m. contained an assessment of the resident's neck. The area to the base of the neck down the lower right shoulder blade areas measured 14 by 7 inches with three sites of irritation noted to the back of the neck and six sites to the right shoulder/back area.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 18 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, the facility failed to ensure that a resident with pressure sores received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for three of three residents sampled with ulcers (Residents #4, #5 and #1). The facility reported a census of 62 residents. Findings include: 1. A Minimum Data Set (MDS) assessment with a reference date of 9/15/18 assessed Resident # 4 with memory problems and moderately impaired decision making skills. The resident required extensive staff assistance with bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. The MDS identified the resident with a Stage 2 pressure sore. Departmental notes dated 9/15/18 at 5:31 a.m. identified the resident with a sore on the sacrum. The area appeared as a brown spot that measured 1 centimeter (cm.) with redness measuring 11 cm. going down the left buttock. The resident admitted to the hospital 9/15/18 for dehydration and returned 9/19/18 at 11:30 a.m. A wound assessment report dated 9/19/18 identified the area on the left buttock as "unchanged". The left buttock contained a Stage	F 686		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 19	F 686		

1 area measuring 3.5 inches by 7 inches and Stage 2 area measuring 0.5 by 1.5 inches. The report identified the area as an abrasion. During interview on 10/24/18 at 1:02 p.m. Staff A RN (Registered Nurse) identified the 9/19/18 area as the same area present on 9/15/18.

On 10/22/18 at 9:45 a.m. the resident went to the wound center for evaluation of the area. The wound center identified the area as a Stage 3 pressure ulcer. The length measured 1.3 cm., width 1.8 cm. by 0.1 depth.

Observation on 10/23/18 at 12:35 p.m. showed that when staff transferred the resident to a recliner, the chair did not contain pressure reduction. The resident remained in the recliner without pressure reduction at the following subsequent observations: 1 p.m., 1:10 p.m., 1:35 p.m., 1:45 p.m. At 2:15 p.m., staff transferred the resident to the wheelchair (1.5 hours without pressure reduction) and at 2:27 p.m. Staff A and Staff B RN provided treatment to the resident's pressure ulcer. The right buttock contained a closed red rashy area measuring 10.5 cm. by 10 cm. The left upper buttock coccyx area was open and measured 1.4 cm. by 2.1 cm. with depth of 0.1 cm. The area was surrounded by a 4.5 cm. by 5.5 cm. reddened area.

Observation on 10/24/18 at 12:02 p.m. showed the resident in the recliner without pressure reduction. The resident remained in the recliner until 1:30 p.m. when she attempted to get out of the recliner per self (1.5 hours without pressure reduction). Staff then transferred the resident to the wheelchair. At 2:20 p.m. the resident sat in a recliner and observation revealed a a urine odor at the time. The surveyor asked Staff C CMA

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 20 (certified medication aide) and Staff D CNA (certified nurse aide) if they took the resident to the bathroom or checked her that day. Staff C and Staff D said no. On 10/25/18 the surveyor viewed camera footage for 10/24/18. Footage showed staff assisted Resident #4 to use the toilet at 9:27 a.m. and then not again until 2:41 p.m., after the surveyor questioned toilet use (5 hours). On 10/24/18 at 3 p.m. Staff D stated the resident was incontinent when they took her to the toilet at 2:41 p.m. The care plan dated 1/22/18 documented staff applied an air overlay mattress to the resident's bed on 9/30/18 (15 days after the pressure ulcer developed). The care plan did not contain a repositioning program intervention until 10/15/18 (a month after the pressure ulcer developed). The care plan also directed staff to take the resident to the toilet before and after meals and at bedtime. The care plan did not address pressure reduction in the chair. On 10/24/18 at 5:30 p.m. the Director of Nursing identified the repositioning program as every two hours. 2. The MDS assessment with a reference date of 8/21/18 assessed Resident #5 with a brief interview for mental status (BIMS) score of 2, indicating severe cognitive impairment. The resident required extensive staff assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS identified the resident at risk for pressure sores and no sores present at the time of the MDS assessment. A physician fax dated 10/11/18 revealed staff	F 686		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21	F 686		

reported a 3.5 cm. by 4.5 cm. non blanchable red discoloration to the resident's left heel and a 1 cm. by 0.5 cm. area of non-intact skin to the left heel. The area appeared as a deep tissue injury. The physician responded on 10/11/18 to float her heels in bed and pad well.

A telephone order dated 10/17/18 identified the resident with a left heel necrotic diabetic ulceration. The physician ordered to apply Betadine (antiseptic) and foam every other day until the ulceration improved. Maintain bunny boot with darker blue material against the sole of the foot to better offload.

Observation on 10/23/18 at 1:35 p.m. revealed the resident in bed to receive a treatment to the heel. At 1:50 p.m. observation showed no dressing on the heel when staff removed the bunny boot. When asked about the lack of dressing to the resident's heel, Staff A RN (registered nurse) and Staff B RN stated the resident had a shower that morning. After the treatment Staff C stated the resident got a shower yesterday, not today.

Observation on 10/24/18 at 1:30 p.m. showed the resident in a recliner with her left heel in a bunny boot resting on the foot of the recliner. The left heel remained on the foot of the recliner until 3:20 p.m. when the surveyor informed the Administrator. The Administrator stated the heel was not free floating and she educated staff to use a pillow to free float the resident's heel.

A wound assessment report dated 10/23/18 recorded the left heel area measured 3.5 cm. long and 3.5 cm. wide. The wound assessment report identified the area as a pressure ulcer.

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22 The resident's care plan updated on 10/11/18 documented skin injuries to the left heel and directed to float the resident's heels. 3. The MDS assessment with a reference date of 8/10/18 assessed Resident #1 with a BIMS score of 12, indicating moderate cognitive impairment. The resident required extensive staff assistance with bed mobility, dressing, toileting and personal hygiene. The MDS identified the resident with MASD (moisture associated skin damage). The resident utilized a suprapubic urinary catheter. The care plan dated 2/25/18 directed staff to turn and reposition the resident every 2 hours. Observation showed on 10/22/18 at 1:30 p.m. the resident in bed on his left side with a wedge behind his back. The resident was still in this position at 3:30 p.m., 4:15 p.m. and 4:30 p.m. (at least 3 hours). On 10/23/18 at 12:20 p.m. observation showed the resident's coccyx area covered with a dressing. The right groin and the area under the abdominal fold were reddened. A Skin assessment dated 10/23/18 at 8:29 a.m. recorded the resident had an 18 cm. by 14 cm. red and moist area to the buttocks, maceration to the peri-rectal area with superficial open areas and a 0.9 cm. by 0.6 cm. open area to the left buttock.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview, the facility failed to did not always fully investigate circumstances leading up to falls and/or did not implement interventions to help prevent falls for one of 11 residents reviewed (Resident #4). The facility reported a census of 62 residents. Findings include: 1. A Minimum Data Set (MDS) assessment with a reference date of 9/15/18 assessed Resident # 4 with memory problems and moderately impaired decision making skills. The resident required extensive staff assistance with bed mobility, transfers, dressing, toileting, personal hygiene and bathing. The MDS did not identify a history of falls. During interview on 10/30/18 at 11:05 a.m. the Director of Nursing (DON) stated staff is to be in the common areas if residents are there. A resident incident report dated 5/16/18 at 3:05 p.m. revealed the resident dropped a blanket and appeared to reach for the blanket causing the resident to slip forward out of the chair. The intervention following the incident was: alarm on when in chair/bed.	F 689		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 24	F 689		

Review of the care plan did not contain the alarm intervention until 7/20/18. When asked how long the resident used the alarm after the 5/16/18 fall, Staff A RN (registered nurse) stated on 10/30/18 at 1:15 p.m. that she did not know.

A resident incident report dated 6/4/18 at 7:30 p.m. recorded a witnessed fall in the unit lobby. Staff found the resident with her feet on the floor and hands holding the handles of the recliner. The resident did not sustain injury. The report did not identify if an alarm sounded or when staff last took her to the bathroom. The report did not identify an intervention after the incident. The care plan contained an intervention dated 6/5/18 instructing staff to redirect the resident when she attempted to self transfer.

Review of a resident incident report dated 6/20/18 at 3:10 p.m. revealed an unwitnessed fall in the living room. Staff observed the resident on her knees in front of the recliner leaning to the right side. The resident did not sustain injury. The investigation did not identify where staff were when the incident occurred or when the resident last used the toilet. The intervention following the incident directed placement of Dycem (to prevent slipping) to her recliner.

A resident incident report dated 7/7/18 at 11:04 a.m. documented an unwitnessed fall in the unit lobby. The resident attempted to self transfer from wheelchair to the recliner without assistance. Other residents stated the resident stood up and then sat down on the floor. The resident did not sustain injury. The report did not identify where staff were, when the resident last used the toilet or if an alarm sounded. Staff placed the intervention to offer 1 to 1 as needed

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 25 after the incident. On 10/30/18 at 10 a.m. Staff C CMA (certified medication aide) stated the staff was in the dining room and could not see the resident who was in the area by the living room. She stated she thought an alarm did sound. Departmental notes dated 7/20/18 at 1:54 p.m. documented approximately 10:45 a.m. the resident fell. Staff observed the resident trying to ambulate independently. The resident took a step and fell forward, hitting her face. The resident had active bleeding to her nose, sustained a cut measuring approximately 0.9 cm. by 0.2 cm. by 0.1 cm. to the upper lip and a small bump to the top of the nose. The facility called the POA (power of attorney) to update her on the incident and staff asked the POA if she wanted the resident sent out (to the physician). The POA said she would be out to check the resident and see how the resident looked. The care plan identified staff placed a personal alarm to the wheelchair and when the resident was in bed and chair. There was no incident report or investigation into the incident. A resident incident report dated 8/5/18 at 1:15 p.m. revealed an unwitnessed fall in the unit lobby. When staff walked across the dining area to take out the garbage, they observed the resident on the floor in front of the recliner. The alarm was in place and did not sound. When staff checked the alarm it functioned. The resident did not sustain injury. The report did not identify if staff was present in the unit lobby prior to finding the resident on the floor. The report did not identify if Dycem was in the recliner. The care plan identified the intervention to encourage the	F 689		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 26	F 689		

resident to sit near staff when restless in recliner. The incident investigation identified the intervention as: staff should encourage the resident to sit in the brown recliner.

Departmental notes dated 8/5/18 at 2:31 p.m. revealed the resident ate lunch and staff took the resident to the toilet. Staff then took the resident into the television area and placed her in a recliner. When the resident asked for assist and staff would offer, then she would say "nothing".

A resident incident report dated 9/25/18 at 7:16 p.m. revealed the resident tried to get out of bed a couple times with the alarm in place on the bed. Staff took the resident to the toilet and put her back to bed. Staff got out to the hall and the alarm again sounded. The resident slid out of bed and staff observed her sitting on the floor by the bed. The resident did not sustain injury. The intervention following the incident documented staff moved Resident #4 to the day hall to monitor as she kept trying to stand per self.

On 9/30/18 at 8:35 a.m. a resident incident report revealed staff observed a 1.5 inch by 2 inch bruise on the resident's right buttock. Staff was unsure if the bruise was from the 9/25/18 fall.

A resident incident report dated 10/5/18 at 6:31 p.m., revealed the resident finished supper and appeared anxious. Staff told the resident several times not to stand. The resident's alarm was on. The resident tried to stand and tipped the wheelchair over. The resident hit her head on the wall and received a bruise on the left shoulder. The intervention after the incident was: staff placed the resident in bed. The care plan intervention was: observe for anxiety and if noted,

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 27 assist to recliner or room for comfort and decreased stimulation. A resident incident report dated 10/11/18 at 7:42 p.m. revealed the resident was in bed and staff heard an alarm and ran to the room to see the resident fall on her bottom. The resident did not sustain injury. The investigation did not identify when staff last toileted the resident. The investigation identified the resident was overstimulated due to the overbed light being on. The intervention was: turn off overbed light when in bed. A resident incident report dated 10/12/18 at 3:24 p.m. revealed staff walked into the resident's room to see the resident on the floor with her feet out before her and back against the wall. The alarm did not sound. The resident received a scrape on the right buttock that measured 2 by 3.5 (no identified centimeter or inches) The intervention on the care plan directed to hang the alarm box out of resident's reach when in bed. The investigation did not identify when staff last saw or helped her to the toilet. A resident incident report dated 10/27/18 at 5 p.m. revealed the resident fell from the wheelchair over the foot pedal hitting her right hip and head on the floor. She had no observed injuries. Staff added an intervention to ensure her foot pedals are off the wheelchair or back when staff not pushing the wheelchair. The surveyor viewed the video of the incident. At 5:03:28 p.m. the resident stood up, staff went to her and sat her back in the wheelchair. Staff left and the resident stood up and fell at 5:03:51 p.m. One staff could be seen in the area with another resident. Department notes dated 10/27/18 at	F 689		

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 _____	C 10/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY LUTHERAN HOME	2323 EAST WILLIS AVENUE PERRY, IA 50220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 28 8:11 p.m. revealed the resident was anxious all evening and staff tried everything. They offered drinks and snacks, toileting but the resident did not settle down. Staff counseled the resident not to stand but she did so anyway and staff could not get to her in time. The report did not identify if she was placed in a recliner or bed as the care plan directed staff to do when anxious and knowing she was anxious did not stay with her to prevent falls. Observation on 10/23/18 at 12:08 p.m. showed Resident #4 in a wheelchair at the dining room table with a staff sitting with the resident assisting her with the meal. During the meal, the resident stood up and her alarm activated. The resident then sat back down by herself.	F 689		

Plan of Correction
Perry Lutheran Home
Survey: October 22 – October 30, 2018

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies were executed solely because provisions of State and Federal law require it.

F609 Completion Date ____11/16/2018_____

1. Resident #7's previous 3 skin issues are resolved as of 11/1/18. All residents skin incident reports have been investigated to include causal factors and appropriate interventions.
2. New Injury of Unknown Origin Tool has been developed to aid in the investigations as warranted for skin issues not witnessed.
3. Staff have been directed on the use of the investigative tool of unknown origin and requirement of reporting to DIA incidents of unknown injury.
4. Concerns will be addressed through QA/QAPI process. Administrator will be notified immediately of any injury of unknown origin.

F610 Completion Date ___11/16/2018_____

1. Resident #7's skin has been assessed and no current injuries of unknown injury. All other residents have been assessed and they have no current injuries of unknown injury.
2. New Injury of Unknown Origin Tool has been developed to aid in the investigations.
3. Staff were educated on investigating injuries of unknown origin and reporting to DIA incidents of unknown origin.
4. Administrator will be notified immediately of any injury of unknown injury. Concerns will be addressed through QA/QAPI process.

F656 Completion Date ____11/16/2018_____

1. Res #2 no longer resides in the facility. Discharge date 8/17/18.
2. Therapy recommendations will be reviewed at the weekly Medicare Meeting and care plans will be updated as warranted. Therapy Discharge notices will include ADL status.
3. Therapy recommendations will be reviewed at the weekly Medicare Meeting and care plans will be updated as warranted. Therapy Discharge notices will include ADL status.
4. Therapy discharge communication sheets will be reviewed during the QA/QAPI meeting.

F658 Completion Date _____11/16/2018_____

1. Resident #5 is no longer a resident in the facility.
2. Staff have been directed that all Dressing changes are to be completed by nurses.
3. Care plans reviewed to ensure skin interventions are in place.
4. Random audits are completed to ensure care plan compliance with equipment. Concerns will be addressed to the QA/QAPI Committee.

F677 Completion date ____11/16/2018_____

1. Res #4 is being toileted as per care plan. Resident # 5 is no longer a resident in the
2. Staff have been directed on providing toileting needs to residents as care planned and fluids are to be offered with cares.
3. Random toileting care audits will be completed to ensure compliance.
4. Concerns will be reported to QA/QAPI committee.

F684 Completion date _____11/16/2018_____

1. Res #4 skin sheets are up to date.
2. Staff have been directed to complete timely assessment and physician / family notifications of noted skin issues.
3. Random skin documentation audits will be completed.
4. Concerns will be reported to QA/QAPI committee

F686 - Completion date_____ 11/6/18_____

1. Residents #4 & #1 skin care plan intervention needs have been reviewed and are currently in place. Res #1 skin issues are resolved.
2. Skin Care plans are current.
3. Audits will be completed weekly x 3months
4. Concerns will be reported to QA/QAPI committee.

F689 - Completion date ___11/16/2018_____

1. Resident #4 – care plan has been reviewed and is up to date.
2. All resident care plans have been reviewed and are current related to fall risks.
3. MDS nurse / designee will review each incident report and update Care Plan
4. Concerns will be reported to QA/QAPI committee.