DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0122	A. BUILDING: _____ B. WING _____	R-C 12/27/2018

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) COMPLETE DATE
N 101	50.7(1) 481- 50.7 (10A,135C) Additional notification. 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(1) Of any accident causing major injury. a. " Major injury " shall be defined as any injury which: (1) Results in death; or (2) Requires admission to a higher level of care for treatment, other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a " major injury " based upon the circumstances of the accident, the previous functional ability of the resident, and the resident ' s prognosis. b. The following are not reportable accidents: (1) An ambulatory resident, as defined in rules 481-57.1(135C), 481-58.1(135C), and 481-63.1(135C), who falls when neither the facility nor its employees have culpability related to the fall, even if the resident sustains a major injury; or (2) Spontaneous fractures; or (3) Hairline fractures. This Statute is not met as evidenced by: Based on clinical record review, observation, facility policy review, and staff interview, the facility failed to report a fracture to the	N 101		12/28/18

DOC 12/28/18

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

POC accepted 1/16/19 VC

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N 101	Continued From page 1 Department of Inspections and Appeals (DIA) for one of one residents reviewed with a major injury (Resident #3). The facility reported a census of 61 residents. Findings: 1. The MDS (Minimum Data Set) assessment dated 11/30/18, listed diagnoses for Resident #3 that included osteoporosis, Non-Alzheimer's dementia, Parkinson's disease (characterized by tremors and an unsteady gait), and lack of coordination. The assessment recorded Resident #3 required the assistance of two staff with transfers and did not walk during the assessment period. The MDS assessed the resident as unsteady and only able to stabilize with staff assistance when moving from a seated to a standing position, moving on and off the toilet, and moving from bed to chair or wheelchair. The resident fell once with a non-major injury during the assessment period. The assessment documented she had a BIMS (Brief Interview for Mental Status) score of 6 of 15, indicating severely impaired cognition. An observation on 12/26/18 at 12:31 p.m. revealed Resident #3 sitting in a wheelchair in the dayroom. The resident had bruising to the right side of her face and wore a soft boot on her right foot. The Incident Report dated 12/15/18 4:30 p.m. documented Resident #3 self-transferred and staff found her on the floor. The sustained a bruise to the right temple measuring 4.5 by .5 centimeters (cm). The 12/16/18 12:35 a.m. Incident Report recorded the resident's right foot was swollen,	N 101		

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N 101	Continued From page 2 dark purple, and she complained of pain with touch. Staff notified the physician and the physician planned to assess the resident in the morning. The 12/16/18 11:51 a.m. Nursing Note recorded the physician assessed Resident #3's right foot and he ordered a soft boot; the resident would see the physician again on 12/17/18. A 12/17/18 2:18 p.m. Nursing Note documented Resident #3 had an X-ray and it was negative for a fracture. The Nursing Note dated 12/18/18 at 9:40 a.m. recorded the physician's nurse called the facility and informed them the resident had a diagnosis of right ankle fracture. A 12/17/18 X-ray report documented the resident had a fracture of the distal fibula (the end of the calf bone). Review of a 12/26/18 Major Injury Determination Form revealed that after reviewing the circumstances of the incident, the resident's previous functional ability and her prognosis, the physician listed the resident's fracture as a major injury. The facility's Accidents/Incidents Investigation and Reporting policy, dated 9/22/17, instructed that staff would report an accident causing a major injury as determined by the attending physician to the DIA within 24 hours of the injury or the next business day. During an interview on 12/26/18 at 1:00 p.m., the DON (Director of Nursing) stated Resident #3 fell out of bed (on 12/15/18) and sustained a bump	N 101		

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N 101	Continued From page 3 on the head. The next night, she had a bruise on the right foot. She stated staff reported to her that she propelled herself, could have gotten her foot caught in the wheelchair and this could have caused the ankle injury. The DON did not know if the injury was caused from the wheelchair or the fall. She stated on 12/17/18, Resident #3 went for an X-ray and the physician reported there was no fracture of the ankle. The DON stated on 12/18/18, the physician reported that it was a fracture. She stated the physician told her on the phone verbally it was not a major injury. She stated she did not have anything in writing regarding this but would try to obtain documentation. She stated she did not report it because she did not think it was a major injury and there was no change in the resident's condition. During an interview on 12/26/18 at 3:30 p.m., the DON provided documentation from the physician and stated the physician deemed the injury a major injury. The DON stated she did not know why the physician told her it was not a major injury on the phone but now stated it was a major injury. The facility reported Resident #3's accident with major injury to DIA on 12/27/18.	N 101		

Plan of Correction

Perry Lutheran Home

Survey: 12/26/18 – 12/27/18

Correction Date: 12/28/18

50.7(1) 481- 50.7 (10A,135C) Additional notification

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.

1. Involved staff were educated about what has to be reported to DIA
2. Review of current process for incident report reviews and follow up
3. Initiation of daily QA meetings with unit coordinators
4. QA committee will monitor monthly

This constitutes the Perry Lutheran Home's written allegation of compliance. All deficiencies will be corrected by 12/28/18.