STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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: 9-29-21 An investigation of Facility Reported Incidents #99492-I, #90537-I and Complaints #94653-C and #96385-C conducted 9/7-28/21 resulted in the following deficiencies. Facility Report #90537-I was not substantiated. Facility Report 99492-I was substantiated. Complaint 94653-C was substantiated. Complaint 96385-C was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. 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 observations, record review, staff and family interviews, the facility failed to provide adequate supervision and proper use of assistance devices to mitigate a resident's risk for elopement for 1 of 5 residents reviewed (Resident #1). On 8/31/21 at approximately 7:45 PM cognitively impaired Resident #1, with a history of wandering and elopement attempts, exited the building by following a visitor out the alarmed front door. Facility staff stated they assumed it	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/11/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 1	F 689		

was the visitor leaving and shut off the alarm. Staff stated they did not know the resident left the building. Approximately 20 minutes later, an off duty staff member observed the resident walking two and a half blocks south on Highway 173. The resident walked on the opposite side of the highway walking with his walker wearing shorts, a t-shirt and shoes. The off duty staff reported minimal traffic at the time she observed the resident. The weather was 71 degrees and no precipitation. The resident revealed he was looking for his wife to have supper with her at the pub and complained of feeling very tired. This resulted in immediate jeopardy for the facility. The facility reported a census of 49 residents.

Findings include:

1. The quarterly Minimum Data Set (MDS) I dated 8/24/21 identified Resident #1 with diagnoses that included: Alzheimer's disease, anemia, coronary artery disease, hypertension, diabetes, dementia, anxiety and depression. The MDS assessed the resident with a Brief Interview for Mental Status (BIMS)score of 3 (severe cognitive impairment). The resident required extensive assistance of 1 staff for dressing, bathing and toileting and required supervision with transfers and ambulation. The MDS revealed the resident fell since admission and identified his balance as not steady during transfer transition and walking.

The Care Plan dated 5/10/19 identified Resident #1 with impaired cognitive function related to dementia. He required supervision with decisions. The care plan also revealed the resident had a potential for elopement last revised on 2/17/20 related to Alzheimer's disease as evidenced by the resident packing his belongings, attempting to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 2	F 689		

leave the facility, talking about returning home and actually leaving the building.

Progress Notes:

On 7/11/21 at 4:10 PM the resident got out the first set of the exit doors at the kitchen but did not make it outside. He exited as a visitor came in. A nurse aide talked the resident back into the facility without further incident.

On 7/13/21 at 10:02 PM earlier in the evening the resident had clothes, cheerios, and other belongings piled high on the seat of his walker. The resident was by the dining room and seated by the front door. Staff tried getting him to go back to his room and he refused saying he was going out that door, pointing to the front door, going to his brothers to get his truck. Staff tried to get him to go to the phone to talk to his wife and he refused. Another staff convinced the resident that his brother was going to be late coming to pick him up and he should wait in his room. The resident then walked back to his room and laid down in his bed.

On 7/15/21 at 9:52 PM the resident was exit seeking and tried to go out the east entrance. When staff intervened, he became angry and threatened to hit staff. He stated he would break the door to leave. Staff got him back to his room.

On 7/24/21 at 3:08 AM the resident was up wandering around and going into others rooms, turning lights on and scared another resident. Staff took him back to his room per a wheelchair as he resisted going to his room.

On 7/31/21 at 11:50 PM the resident walked the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 3	F 689		

halls with his walker and stated he planned to go buy beer. The resident kept pushing on the front door and did get the first door open sounding the alarm. It took four staff members to get him back to the nurse's station to call his wife. She did not answer so staff left a message for her. The resident sat at the nurse station for a while and then went back to his room.

On 8/31/21 at 8:32 PM staff found the resident outside the facility. He returned to the facility with no injuries noted. The staff notified the physician and family.

On 9/3/21 at 3:01 AM resident not sleeping well tonight and walked the halls.

On 9/6/21 at 10:54 PM the resident came out of his room and stated he had things to do. Staff informed him everyone was in bed. He sat in the lounge for a while and then went back to his room.

On 9/8/21 at 11:31 PM the resident used his tray table for support and pushed it out of his room and brought it into the nurses station. He stated would take the table out the door. Staff redirected him to his room but he returned to the hall pushing himself on his walker around the halls going into other residents rooms.

On 9/13/21 at 9:48 PM the resident is awake and trying to leave the facility. He is looking for his wife and stated he's going to break out a window to get away from the facility if he has to.

Administrator Interview Summary of Incident:

On 9/7/21 at 2:20 PM the Administrator stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 4	F 689		

evening of 8/31/21 there was a family member of another resident that set off the alarm to the main entrance when she brought her dad back into the facility. She immediately told a staff member that she set off the alarm and she added that she is now leaving in case she sets it off again. The Administrator stated one of the facility aides, Staff C certified nurse aide (CNA), lives next door, was off shift and out for an evening walk. The aide saw Resident #1 downtown across from the town pub walking on the sidewalk. Approximately 20 minutes lapsed from the time the main entrance door alarm sounded until the off duty aide saw the resident. The aide reported the resident was walking with his walker wearing shorts, a t-shirt and shoes. He told the off duty aide he planned to meet his wife for dinner at the pub but could not find her. He stated he felt very tired and denied injury. The Administrator stated it was 77 degrees outside with a light breeze and no precipitation. There were no restaurants or businesses open that night so there was not much traffic. The Administrator stated the aide took the resident back to the facility. Staff working reported they did not know the resident left the facility until the aide brought him back. The aide working Staff D CNA, assumed the door alarm that went off was the family member leaving so she silenced the alarm without looking to see if a resident left. Upon return to the facility, a nurse assessed the resident with no injuries found. The Administrator stated when he called and interviewed the family member, he asked about the possibility of Resident #1 following her outside. The family member stated she did see someone behind her but she didn't pay attention to who it was. The facility immediately hung signs for visitors to alert them to watch for residents behind them when they leave. They educated all staff on 9/1/21 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 5	F 689		

door alarm and elopement policy and procedures. He added that he also educated the family member involved and the Social Services Director followed up on the resident and his exit seeking behavior.

Observations:

Observation of care on 9/7/21 at 3:10 PM showed the court yard door opened and the door alarm sounded. Staff A CNA, immediately responded to the alarm. She stated it is facility policy that when a door alarm sounds they are to go to the panel on the wall and see which door it is. They then alert staff and go to that door to investigate who went out. If they do not find anyone outside the door, they are to start a resident head count and start full elopement procedure.

On 9/7/21 at 3:15 PM Staff B stated as soon as a door alarm sounds they are to check the panel and see which door it is. They then go and check that door to see who went out. They are not to shut off the alarm until there is an all clear.

Observation on 9/7/21 at 4:10 PM revealed the facility on the east side of highway 173 and the pub on the west side of highway 173. The pub is down a hill approximately 2 to 3 blocks south. The edge of town is 3 blocks farther south and the highway continues south with a gravel shoulder and corn fields on each side of the highway.

Staff involved with the incident:

On 9/8/21 at 12:32 PM with Staff C CNA stated she worked as a bath aide on day shift at the facility and worked at the facility for 17 years. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 6	F 689		

lives across the street from the facility and on the evening of 8/31/21 she stated she walked uphill going north on the highway that runs through town and saw the resident on the sidewalk in front of the pub approximately 2 ½ blocks from the facility walking downhill going south. She stated it was around dusk but not dark yet. She stated the resident was on the opposite side of the facility and wore shorts, a t-shirt and shoes. When she approached, the resident recognized her and told her he was looking for his wife because he planned to meet her for supper. He told her was okay and just very tired. She stated businesses close on Tuesday nights so there was not much traffic. Staff C stated there was a lady across the street that she knew and the lady came and assisted to get the resident into her car to take him back to the facility. Staff C stated she helped get him into the facility with the help of Staff D and then she left to go back home once she knew he was safe.

On 9/8/21 at 1:00 PM with Staff D CNA stated she helped get the resident back into the facility. She stated the facility staff did not know the resident got out because all the staff working assumed it was a family member leaving. She stated the charge nurse told her a family member just left so she shut off the door alarm without checking for any residents outside. She stated she took the resident back to his room and helped him get ready for bed. He told her he had been on an adventure and felt very tired. She stated the facility trained all the staff the next day about elopement and door alarms.

On 9/8/21 at 1:59 PM the Director of Nursing (DON) stated the highway the resident was found on is county highway 173 and the speed limit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 7	F 689		

through town is 25 miles per hour.

The Door Alarm Policy dated 5/7/19 documented:

The staff member that answers the alarm at the alarm panel must double check to assure accuracy, which alarm is sounding prior to silencing the alarm.
The alarm is not to be turned off until a staff member goes to the door and assures that a resident has not left the building.
If a second staff member is available, the staff member silencing the alarm should direct the second staff member to page overhead, please check the west door, and please check the west door.
This includes going outside to rule out elopement.
If you see someone and are not sure who they are, please ask questions that will help determine if this is a resident or a guest. If no one is observed and staff is unable to verify who sounded the alarm, a resident head count must be completed to rule out elopement.
If a resident is unaccounted for at head count, the elopement policy will be implemented.
When it has been confirmed that the alarm was not an elopement, an all clear will be paged overhead so that all staff is aware that the alarm was answered and followed up appropriately.
Once hearing the page, west door clear, west door clear, the alarm may be silenced.

On 9/8/21 at 3:28 PM with Resident #2's daughter stated her dad is a resident at the facility. He wanted to go on a ride that evening and they returned to the facility. She stated she backed up to the facility to get him out of the car easier. She noticed she set the alarm off when she took him in so she let the nurse know it was her and that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 8 she was leaving in case the door alarm sounded again. She stated when she left she was upset because her dad was upset about her leaving him and she was in a hurry to leave. She stated she remembered seeing someone up by the front entrance but did not pay attention to who it was. As she left, she punched in the door code and went out. As she drove off, her car did not face the facility so she did not see if anyone followed her out. She stated it was possible someone followed her out. She stated the facility saw on camera that the resident followed her out. The facility called her and did training with her and she stated she will never let anyone follow her out again. Immediate Jeopardy Removal: The facility removed the immediate jeopardy on 9-1-21 after they hung signs for visitors to alert them to watch for residents behind them when they leave and educating all staff on 9/1/21 on door alarm and elopement policy and procedures. The facility also educated the family member involved and the Social Services Director followed up on the resident and his exit seeking behavior. Facility action to remove the immediate jeopardy resulted in past noncompliance. The State Agency notified the facility of the immediate jeopardy on 9-9-21.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 880	Continued From page 9 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 880	Continued From page 10 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to implement a comprehensive infection control program to mitigate the risk of spread of infection. The facility failed to ensure staff wore PPE according to CMS and CDC guidelines and failed to provide proper hand hygiene for 3 of 5 residents reviewed (#3, 1 and 7). The facility reported a census of 49 residents. Findings include: 1.The quarterly Minimum Data Set (MDS) dated 6/29/21 identified Resident #3 with diagnoses that included: hypertension, cerebrovascular disease (CVA) with hemiplegia, malnutrition, anxiety, depression, bipolar, psychotic disorder, and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 880	Continued From page 11	F 880		

schizophrenia. The MDS asssessd the resident with a Brief Interview of Mental Status (BIMS) score of 2 (severe cognitive impairment). The resident required total assistance of 2 staff for transfers and toileting, extensive assist of 2 staff for bed mobility, dressing, and hygiene. The resident did not ambulate and was always incontinent of bowel and bladder.

The Care Plan dated 10/3/14 identified Resident #3 with impaired cognitive function related to CVA, history of drug abuse, bipolar disease and schizophrenia, and a self-care deficit related to CVA. The resident was dependent with toileting, requires assist of two for pericare, and clothing management.

Observation of care on 9/21/21 at 12:45 PM revealed Staff F CNA and Staff H CNA enter Resident #3's room. Staff washed their hands and explained cares to him. They hooked him up to the high back sling under him and raised him with a full body lift. The resident transferred to bed for perineal care. Both staff applied clean gloves. They rolled him to lower his pants and then removed his wet brief by folding it down in between his legs. Staff H handed Staff F wipes and she used one wipe to clean his front groin and penis. She then discarded the dirty wipe in between his legs with the wet brief. Staff F rolled him to his right side while still wearing the same gloves worn for perineal care. Staff F touched the sling to pull it flat and rolled the rest of the wet brief under him. She used the second wipe to clean his buttock area folding the wipe for each cleaning motion. Staff F then grabbed the container of wipes from the dresser while still wearing the same gloves for perineal care. She continued to finish perineal care to the back

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 880	Continued From page 12	F 880		

buttock area. She then obtained a clean brief from the dresser, placed it on the bed, and then removed her dirty gloves. Staff H removed her gloves and both aides sanitized. They rolled the resident, applied the clean brief, and adjusted his clothing.

The policy Perineal Care dated 4/16/21 directed staff to apply gloves prior to removing a soiled pad and to remove soiled gloves, wash hands or sanitize and re-glove after removing the soiled pad. After perineal care remove soiled gloves, use hand sanitizer or wash with soap and water and put on clean gloves before putting on a clean pad and/or clothing.

On 9/21/21 at 3:20 PM the Infection Control Nurse stated aides are expected to change their gloves when going from front perineal care to back perineal care and they are expected to change their gloves and sanitize after perineal care before touching any clean areas.

2. The quarterly Minimum Data Set (MDS) dated 8/24/21 identified Resident #1with diagnoses that included: Alzheimer's disease, anemia, coronary artery disease, hypertension, diabetes, dementia, anxiety and depression. The MDS assessed the resident with a BIMS score of 3 (severe cognitive impairment). The resident required extensive assistance of 1 staff for dressing, bathing and toileting and required supervision with transfers and ambulation.

The Care Plan dated 5/11/19 identified Resident #1 with a self-care deficit related to dementia and directed staff to toilet the resident as needed due to he is occasionally incontinent of bladder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 880	Continued From page 13 Observation of care on 9/21/21 at 10:50 AM revealed Staff E CNA wash her hands and then explain cares to Resident #1. While in his room, washing her hands and speaking to him her mask was down under her nose for approximately 5 minutes. The resident did not have a mask on. She adjusted it up prior to assisting him to the bathroom. 3. The quarterly Minimum Data Set (MDS) assessment tool dated 7/13/21 identified Resident #7 with diagnoses that included: dementia, hypertension, seizure disorder, malnutrition, depression and osteoarthritis. The MDS revealed the resident demonstrated severe cognitive impairment. The resident required extensive assistance of 2 staff for bed mobility, transfers, dressing, hygiene, and bathing and is non-ambulatory. The Care Plan dated 1/16/15 identified Resident #7 with a self-care deficit and directed staff that she needs assist to eat as she will allow and to supervise and encourage her to eat. Observation of the noon meal on 9/21/21 at 11:50 AM revealed Staff A CNA leaned over and spoke to Resident #7. Staff A's mask covered her mouth but was down under her nose. Staff A adjusted the mask to cover her nose after speaking to the resident. The resident did not wear a mask. The policy Emerging Threats-Acute Respiratory Syndromes Coronavirus dated 9/14/21 directed all employees in all locations to wear masks at all times, regardless of vaccination status and ability to social distance.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(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 880	Continued From page 14 On 9/21/21 at 3:20 PM the Infection Control Nurse stated all staff are expected to wear a mask that covers their mouth and nose when in the facility around residents or providing resident care.	F 880		

F000 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual

Tag: F880 Infection Prevention & Control

1. **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

Proper PPE use education given by Director of Nursing Services immediately after notification of concern on 09/21/2021.
Peri care education provided to staff F and staff H on 09/21/2021 by Director of Nursing Services when process break was recognized by Infection preventionist

2. **Address how facility will identify other residents having the potential to be affected by the same deficient practice.**

This has the potential to affect all residents in nursing home with policy and regulation of PPE needing to be worn and all residents requiring assistance with pericares.

3. **Address what measures will be put into place or what systematic changes made to ensure that the deficient practice will not occur.**

Infection preventionist provided education on September 21, 2021 regarding proper PPE use. This included mask covering both nose and mouth at all times while with a resident. Infection preventionist provided education on September 21, 2021 regarding proper peri care and hand hygiene. This included appropriate times to change gloves, use hand sanitizer or wash with soap and water. You Tube courses on *PPE Lessons* and *Clean Hands* will be

completed by all staff by 10/26/21. No staff will be allowed to work past this date if they courses are not complete. RCA completed on 10/15/21 with Administrator, Director of Nursing Services, QA Director, Corporate Nurse Consultant and Corporate Quality Improvement Advisor.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**

Audits will be completed by infection preventionist or designee and will include review of proper PPE use, pericare and hand hygiene.. Audits will be done 3 times per week x 2, then weekly x 4, then bi-weekly x 2 and then monthly x 2. All audit results will be brought to monthly Quality Assurance and Performance Improvement committee for any further review and recommendations.

Compliance Date: 09/29/2021