STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165552	A. BUILDING _____ B. WING _____	C 12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VINTON LUTHERAN HOME	1301 SECOND AVENUE SOUTH VINTON, IA 52349

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F 000	INITIAL COMMENTS OK ✓ Correction Date: January 14, 2021 T&P A Focused COVID-19 Infection Control Survey and an investigation of Complaint #93827 and a Mandatory #94031 was conducted by the Department of Inspections and Appeals on 12/7-14/2020. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The following deficiency relates to the Mandatory investigation. (See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C). Census: 44	F 000	F000 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. All deficiencies included in the report will be corrected as of January 14, 2021.	
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	F 609	F609: On 12-28-20 the Director of Nursing (DON) developed an educational document instructing all staff on the requirement of all staff to report potential abuse immediately to the charge nurse, who will then report it to a nurse manager. The educational document also included our facility Policies and Procedures, which directs all staff to immediately report any suspected abuse and the management team will report within 2 hours to the Department of Inspections and Appeals.	

LABORATORY DIRECTOR S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kellie VanTee | TITLE: RN/Administrator | (X6) DATE: 12-29-20

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.

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F 609	Continued From page 1 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 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy and staff interviews the facility failed to ensure staff responded to an allegation of abuse and report the allegation within the required timeframe as per regulations. (Resident #1). The facility reported a census of 44 residents. Findings include: Record review showed Resident #1 admitted to the facility on 7/27/2020 and resided in the Memory Care Unit. The Minimum Data Set (MDS) Assessment Tool dated 8/3/2020 revealed Resident #1 with severely impaired cognitive skills for daily decision making, hallucinations, delusions, and wandering behaviors. The resident ambulated independently in the room and required limited assistance with transfers, dressing and hygiene. The Care Plan revealed the resident received psychotropic medications for depression and anxiety, and the resident had behaviors. The Care Plan directed staff to determine the cause for behaviors and provide support, consult Behavioral Health and adjust medications. The Care Plan also directed staff to have another staff approach the resident and attempt to provide	F 609	The educational document will be signed by all staff indicating they have read and understand the reporting requirement. This must be returned to the DON or Administrator by January 5, 2021. Following January 5, 2021 the DON or Administrator will audit for all staff signatures and educate those that are not indicated on the sheet. The DON or Designee will perform Quality Assurance monitors on report sheets, verbal report, incident reports and any other documentation pertinent for potential abuse situations. The DON or Designee will perform Quality Assurance monitors to assure staff verbalize understanding on the reporting requirements for potential abuse allegations.	

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F 609	Continued From page 2	F 609		

cares if agitated.

Review of the resident's Progress Notes included:
a. On 10/16/2020 at 12:16 p.m., Staff A, Director of Nursing (DON) documented staff notified the physician and reported the resident had increased paranoia behaviors. The physician ordered an increase in psychotropic medications.
b. On 10/16/2020 at 2:22 p.m., Staff B, Certified Medication Aide (CMA) documented when he/she arrived at work the resident worried that men were coming and he/she stuck by Staff B most of the morning. Staff B put a different jacket on the resident and noticed a bruise on his/her right arm. Staff B notified Staff A, DON.
c. On 10/16/2020 at 10:41 a.m., Staff A, DON documented Staff B related on Tuesday, 10/13/2020, the resident was in the bathroom with Staff C, Certified Nurse Aide (CNA) and Staff B heard the resident scream. The resident came to the desk and stated Staff C grabbed and twisted his/her arm. Staff C and Staff D, CMA were both at the desk at this time and witnessed the resident's statement. Staff B looked at the resident's arm and saw no marks at the time. This morning Staff B noted a large bruise on resident's right arm, 8 inches by 2.4 inches in a linear shape along the lateral aspect of arm, purple, green, brown and slightly swollen. No other marks or areas of concern noted per assessment.
d. Staff educated that they should have reported incident immediately when it happened. The Department of Inspections and Appeals (DIA) notified of incident.
e. On 10/19/2020 at 2:55 p.m., Staff E, Licensed Practical Nurse (LPN)/ Assistant Director of Nursing (ADON) documented the physician's nurse called regarding the resident's right arm

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F 609	Continued From page 3	F 609		

x-ray and wanted him/her to see a specialist. The specialist called and said the only thing he would do is put the resident in a sling and he did not like doing that with dementia patients. The resident continues to use his/her arm without problem, not hurting and not guarding it.

Skin observations included:
10/16/2020 - Acquired bruise right lateral forearm. First Observation. 200 mm (Millimeters) long by 53 mm wide.
10/19/2020 - Improving, fading and smaller. 70 mm by 30 mm.
10/26/2020 - healed.

Incident Report documented the following:
Date of Incident: 10/13/2020 at 7:00 p.m..,
Resident #1, Memory Care Unit.
Staff B, CMA, Staff D, CMA and Staff B, CNA.
Resident was heard yelling and came out to nurse's desk, told Staff B and Staff D that Staff C twisted his/her right arm 'like this' and demonstrated. Staff stated they looked at resident's arm and did not see any marks.
10/16/2020 - Dr. Guerber notified at 10:40 a.m..
Assessment of resident's arm had no pain, swelling and has full range of motion and good brachial and radial pulses. Resident denied numbness/tingling. Staff C removed from schedule until investigation completed by DIA. On 10/17/2020 resident complained of pain and holding arm. X-ray ordered of right arm, Question of fracture radial head, lateral osteophyte versus mild impaction fracture. Physician declined to splint due to causing increased agitation.

X-ray dated 10/17/2020: Right Forearm injury, pain, and swelling. Osteoporosis. Degenerative changes left elbow and wrist. Suspect small joint

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F 609	Continued From page 4	F 609		

effusion. Prominent lateral osteophyte (bone spur) of the radial head neck junction versus mild impaction fracture. Consider dedicated three view, right elbow x-ray series with radial head view.

Observations on 12/7/2020 included the resident wandering in the Memory Care Unit independently without an assistive device. He/she participated randomly in activities offered. Staff assisted resident to the bathroom where he/she cooperated without any behaviors.

During an interview on 12/9/2020 at 12:45 p.m., Staff A, DON revealed on 10/16/2020 Staff B came and explained what had happened on 10/13/2020. Staff C, CNA and Resident #1 were in the bathroom, Staff B heard screaming from the resident's room. The resident came out and said, "He/She bent my arm". Staff B checked the resident's arm and did not observe anything. Staff B reported off to Staff D, CMA who was also there. That night the resident had agitated and wandering behaviors and attempted to leave the facility. When the resident attempted to leave, he/she hit the door with his/her forearm while attempting to open the door. Staff C and Staff D both witnessed this. The bruising did not have any finger marks. The x-ray showed a questionable fracture and the physician chose not to treat it with a sling due to the resident's dementia. On 10/16 when Staff B reported the allegation, they began the investigation. Staff C has had resident complaint of Staff C being rough or pushy and they followed up with staff education. Resident #1 had no recall of the October 13 incident when Staff A asked him/her about it. Staff C did work the entire shift the evening of 10/13 until the next morning. Staff C

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F 609	Continued From page 5	F 609		

worked again on that Thursday evening until Friday morning in the Memory Care Unit. On Friday morning, October 16, Staff B observed the resident's bruise and came to Staff A. Staff A followed up with Staff B and Staff D regarding immediate reporting of abuse allegations.

During an interview on 12/9/2020 at 1:10 p.m., Staff B, CNA, CMA reported working in the Memory Care Unit on 10/13/2020 and 10/16/2020 from 6:00 a.m. until 6:30 p.m..

On 10/13/2020, Staff B was counting medications with Staff D, oncoming staff at 6:30 p.m. and Staff C, CNA took Resident #1 to his/ her room for bedtime cares. Staff B and Staff D heard a scream coming from the resident's room with the door shut. The resident came out, appeared very anxious, and came up to the desk, held up his/her right arm and said he/she hurt my arm. Staff B looked at his/her arm and saw no marks. The resident called Staff C, CNA names and said he/she twisted his/her arm. Staff C came out and said he/she did not do it. Staff B gave the resident water to drink and he/she calmed down and did eventually go back to his/her room with Staff C to finish cares. Staff D also witnessed everything and took over from there. On the morning of 10/16/2020, Staff B assisted the resident with morning cares and observed the bruise on his/her right forearm around 7:00 a.m.. Staff B went and reported it to Staff A and asked if anyone had reported anything. Staff A said 'no". Staff B assumed Staff D would follow up because Staff B finished working and left for the night.

During an interview on 12/9/2020 at 2:10 p.m., Staff D, CNA/CMA reported working in the unit on 10/13/2020 at 6:30 p.m. and took Staff B's place.

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F 609	Continued From page 6	F 609		

Staff C took Resident #1 willingly to his/her room. Staff D heard a scream and the resident came out of his/her room very agitated, held his/her right arm and said, "He/she tried to kill me". Staff C came out and said he/she tried to get the resident ready for bed. Staff B calmed the resident and said he/she could go with Staff C to get ready for bed. The resident willingly went with Staff C. It was a bad night for the resident, he/she followed them into every room and tried to leave. The resident tried to get into Edna's room that night and became more agitated as they tried to keep him/her out.

During an interview on 12/9/2020 at 9:30 a.m., Staff C, CNA reported working as a CNA for four years primarily the night shift in the Memory Care Unit. Staff D reported on 10/13/2020 he/she assisted the resident in the bathroom. The resident became anxious as he/she feared Staff B would leave him/her behind. Staff C failed to recall if the resident screamed but remembered the resident bumped into him/her as he/she exited the room and went to the nurse's station. The resident told Staff B and Staff D that Staff C tried to break his/her arm. Staff C told them he/she did not do it and nobody said anything more about it. During the night the resident tried to elope but the alarms sounded and the resident remained inside. On Thursday night, Staff C worked again and the resident had no issues and everything went well. After Staff C got home from work on Friday, October 16, Staff A called and asked what happened on Tuesday night. Staff A came and wrote a statement. A week or so later an officer called and asked some questions.

The facility Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and

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F 609	Continued From page 7	F 609		

Reporting Guidelines reviewed on 6/27/2018 included:
a. It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation and misappropriation of resident property. These procedures shall include the screening and training of employees, protections of Residents and the prevention, identification, investigation, and timely reporting of abuse, neglect, mistreatment, and misappropriation of property, without fear of recrimination or intimidation.
b. Investigation: It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse including injuries of unknown source, resident to resident abuse, exploitation and misappropriation of property) are promptly and thoroughly investigated.
c. Protection: It is the policy of this facility that the resident will be protected from the alleged offender. Procedures must be in place to provide the resident with a safe, protected environment during the investigation. Immediately upon receiving a report of an allegation of resident abuse, neglect, exploitation, or mistreatment the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation is in process. The alleged perpetrator will immediately be removed and resident protected. Upon receiving a claim of dependent adult abuse this separation will be maintained until the department's abuse investigation is completed and the abuse determination is made. Staff members accused of the alleged abuse will be immediately removed from the facility and will remain removed pending the results of a thorough investigation. When resident is safe you need to inform the charge nurse on duty. The

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F 609	Continued From page 8	F 609		

charge nurse will examine, assess and interview the resident and other residents potentially affected to determine the injury. The DON, Administrator and COO (Chief Operating Officer) shall be immediately notified of an alleged abuse to begin an investigation and complete the reporting requirements.

Time clock records revealed Staff C, CNA worked 10/13/2020 5:54 p.m. until 10/14/2020 at 6:30 a.m. and 10/15/2020 5:58 p.m. until 10/16/2020 at 6:43 a.m..