STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165432	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN LIVING SENIOR CAMPUS	2421 LUTHERAN DRIVE , MUSCATINE, Iowa, 52761

(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
F0000	INITIAL COMMENTS Correction date: _____ The following deficiencies resulted from investigation of complaints #1746939-C, #1746946-C, #1746954-C, #1746956-C, #1746958-C, #1746960-C and #2574374-C and facility reported incidents #1746948-I, #1746952-I and #2573332-I conducted July 30, 2025 to August 7, 2025. Complaints #1746946-C, #1746954-C and #2574374-C resulted in a deficiency. Facility reported incident #2573332-I resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0553 SS = D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F0553		

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 reverse for further 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.

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

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F0553 SS = D	Continued from page 1 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, family and staff interviews, and policy review, the facility failed to conduct quarterly Care Conferences (CC) for 1 of 3 residents reviewed (#4). The facility reported a census of 124 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #4 dated 3/26/25 did not include a Brief Interview for Mental Status (BIMS) score; however, an MDS assessment dated 12/27/24 revealed a BIMS score of 06 out of 15, which indicated severely impaired cognition. The MDS dated 3/26/25 included diagnoses of coronary artery disease (CAD), congestive heart failure (CHF), Alzheimer's Disease, non-Alzheimer's dementia, venous insufficiency, and seborrheic dermatitis (a common skin condition that causes a scaly, flaky, itchy rash, often on the scalp, face, and body folds). The Care Plan dated 2/24/23 indicated the resident had potential for complications with impaired skin integrity including skin tears, bruising AND/OR pressure related to current medical and physical status and had lower extremity (LE) edema. There were four (4) modifications made to the Care Plan's skin integrity focus. During an interview on8/04/25 at 12:27 PM, a family member stated Care Conferences were never completed. On 8/05/25 at 5:12 PM, Staff D, Social Services designee (SS) stated Care Conferences (CC) are	F0553		

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F0553 SS = D	Continued from page 2 scheduled 1 -2 weeks after MDS assessments are completed quarterly to ensure the resident's information is current. She also stated the resident and resident's representative are notified by mail and are contacted the day before the scheduled Care Conference if no confirmation is received. She added she has been the SS designee since 5/07/25 and documents CC in the resident's electronic health record (EHR) so she was not aware if previous CC summaries were stored on paper. The EHR indicated MDS assessments were completed 7/23/24, 10/15/24, 12/27/24, 3/26/25, and 6/17/25. The Assessments tab revealed Care Conference Summaries were documented on 7/31/24 and 6/17/25. There were no documented summaries for 10/24, 12/24, or 3/25. During an interview on 8/07/25 at 12:21 PM, the Director of Nursing (DON) stated a Care Plan conference should have occurred every quarter or upon a change of condition. A policy titled "Care Plan – Reviews/Conferences" reviewed 8/07/25 indicated the community will conduct a care plan review/conference at least quarterly, and as needed, that is interdisciplinary, provides an in-depth review of the resident's plan of care, and provides an opportunity for resident and resident representative and/or family discussion/input.	F0553		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F0580		

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F0580 SS = D	Continued from page 3 treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, family and staff interviews, and policy review, the facility failed to provide timely physician and family notification for 1 of 3 residents (Resident #4) who experienced a newly documented open wound. The facility reported a census of 124 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #4 dated 3/26/25 did not include a Brief Interview for Mental Status (BIMS) score; however, an MDS assessment dated 12/27/24 revealed a BIMS score of 06 out of 15,	F0580		

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F0580 SS = D	Continued from page 4 which indicated severely impaired cognition. The MDS dated 3/26/25 included diagnoses of coronary artery disease (CAD), congestive heart failure (CHF), Alzheimer's Disease, non-Alzheimer's dementia, venous insufficiency, and seborrheic dermatitis (a common skin condition that causes a scaly, flaky, itchy rash, often on the scalp, face, and body folds). It also revealed the resident was independent with rolling left-to-right, sit-to-lying, and lying-to-sitting on the side of the bed, and required supervision with all other mobility. It further revealed, based on clinical assessment, the resident did not have any unhealed pressure ulcers or injuries and did not have any venous or arterial ulcers. It indicated the resident received dressings to his legs and feet. The Care Plan dated 8/29/23 indicated the resident had potential for complications with impaired skin integrity including skin tears, bruising AND/OR pressure related to current medical and physical status and had lower extremity (LE) edema. It directed staff to observe skin with AM/PM cares and with toileting for redness, rashes, open areas, pain, swelling and report them to team leader and review skin concerns with medical doctor (MD). The electronic health record (EHR) included the following physician's order dated 2/06/24: Skin Management: Weekly Body Observation and Form to be completed 1x Week. Open Weekly Skin Check Tool in assessments and complete every evening shift every Tuesday for Prevention. If impairments present, measure and document a skin/wound progress note. Another physician's order dated 10/15/24 directed staff to notify provider if any increase in swelling, scratching or new lesions. A Physician Progress Note dated 4/14/25 indicated an increase in the resident's LEs (lower extremities) and included an order to increase the resident's furosemide (diuretic – medication that increases urination to remove excess water) to 60 milligrams (mg) by mouth twice daily. The Weekly Skin Assessment dated 4/15/25 included additional information of redness to bilateral lower extremities (BLE), left shin has small open area approximately 1.5 in in length x 0.5 in width. Treatments as ordered. It did not include documented MD or family notification. The Weekly Skin Assessment Question History did not include previously measured BLE open areas.	F0580		

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F0580 SS = D	Continued from page 5 Review of the Nurse Progress Notes for 4/15/25 did not include MD (medical doctor) or family notification for the new BLE open area. On 8/06/25 at 12:33 PM, Staff C, Licensed Practical Nurse (LPN) stated the MD, family, and Assistant Director of Nursing (ADON) or Administrator On-Call (AOC) should be notified of newly identified resident skin wounds and notifications are documented in the Nurse Progress Notes. She also stated she didn't recall whether or not she contacted the MD or resident's family. On 8/07/25 at 12:21 PM, the Director of Nursing (DON) stated staff should have called the family and physician. They should have initiated any standing orders and continued attempts to contact the physician and document the call. A policy titled "Notification of Change" reviewed 8/07/25 indicated the community will consult the resident's physician, nurse practitioner, or physician assistant and notify the resident representative or an interested family member when there is: a. An accident (including falls) which results in injury and has the potential for requiring physician-intervention. b. Acute illness or a significant change in the resident's physical, mental, or psychosocial status (i.e., deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). c. A need to alter treatment significantly (i.e. a need to discontinue or change an existing form of treatment due to adverse consequences or to commence a new form of treatment). d. A decision to transfer of discharge the resident from the community. e. A change in resident rights. f. Changes in skin integrity, abnormal labs, changes in cognition, signs/symptoms of infection/virus, etc…any change that would constitute the need to alter the resident's orders and care for the resident.	F0580		
F0628 SS = B	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)	F0628		

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F0628 SS = B	Continued from page 6 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F0628		

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F0628 SS = B	Continued from page 7 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F0628		

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F0628 SS = B	Continued from page 8 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F0628		

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F0628 SS = B	Continued from page 9 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, long term care ombudsman interview, and staff interview, the facility failed to cite the correct chapter of the Iowa Legislature State Regulations when issuing an involuntary discharge notice to 1 of 1 residents (Resident #1) reviewed. The facility reported a census of 124 residents. Findings include: The Minimum Data Set (MDS) of Resident #1 dated 6/4/25 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS	F0628		

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F0628 SS = B	Continued from page 10 recorded the resident experienced mood symptoms of feeling down, depressed, or hopeless on one day of the lookback period. The MDS recorded the resident dependent upon staff assistance for chair/bed-to-chair transfers. The MDS documented diagnoses that included: paraplegia, anxiety, depression, and alcohol abuse with alcohol-induced mood disorder. On 6/30/25, the facility addressed and hand delivered an involuntary discharge notice to Resident #1. The document, dated 6/30/25, titled Emergency Notice of Involuntary Discharge referenced Iowa Administrative Code 481-57.14(2) as state rule and regulation governing involuntary transfer. The document advised Resident #1 of being discharged to an appropriate facility or placement that can meet his needs and that he was being discharged due to his behavior posing a threat to the health and safety of other residents. During an interview on 7/31/25, the Long-Term Care Ombudsman stated the facility cited the wrong Iowa Administrative Code on the discharge notice. The LTCO stated Chapter 57 documented on the notice applies to Resident Care Facilities. The LTCO explained the facility should have referenced Chapter 58 for Long Term Care Facilities. She stated this error would normally have made the notice not be applicable and it should have been rewritten and the discharge process started over when this was completed. She added she was out of town during the proceedings, and when Resident #1 appealed the decision, the Administrative Law Judge upheld the discharge due to the facility having substantially complied with the notice requirement and the resident did not argue with the manner of the notice. During an interview on 8/6/25 the Administrator stated he had corrected the verbiage to Chapter 58 for any future involuntary discharges.	F0628		
F0684 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.	F0684		

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F0684 SS = D	Continued from page 11 This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, family and staff interviews, the facility failed to provide timely interventions for 1 of 3 residents who experienced a newly documented open wound (#4). The facility reported a census of 124 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #4 dated 3/26/25 did not include a Brief Interview for Mental Status (BIMS) score; however, an MDS assessment dated 12/27/24 revealed a BIMS score of 06 out of 15, which indicated severely impaired cognition. The MDS dated 3/26/25 included diagnoses of coronary artery disease (CAD), congestive heart failure (CHF), Alzheimer's Disease, non-Alzheimer's dementia, venous insufficiency, and seborrheic dermatitis (a common skin condition that causes a scaly, flaky, itchy rash, often on the scalp, face, and body folds). It also revealed the resident was independent with rolling left-to-right, sit-to-lying, and lying-to-sitting on the side of the bed, and required supervision with all other mobility. It further revealed, based on clinical assessment, the resident did not have any unhealed pressure ulcers or injuries and did not have any venous or arterial ulcers. It indicated the resident received dressings to his legs and feet. The Care Plan dated 8/29/23 indicated the resident had potential for complications with impaired skin integrity including skin tears, bruising AND/OR pressure related to current medical and physical status and had lower extremity (LE) edema. It directed staff to observe skin with AM/PM cares and with toileting for redness, rashes, open areas, pain, swelling and report them to team leader and review skin concerns with medical doctor (MD). The electronic health record (EHR) included a physician's order dated 10/15/24 that directed staff to notify provider if any increase in swelling, scratching or new lesions. The Weekly Skin Assessment dated 4/15/25 included a redness to bilateral lower extremities (BLE), left shin has small open area approximately 1.5 in in length x 0.5 in width that was not previously identified. Treatments as ordered. The assessment tool lacked a documented intervention. The Nurse Progress Notes for 4/15/25 did not include a documented intervention for the new BLE open area.	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165432	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0684 SS = D	Continued from page 12 On 8/06/25 at 12:33 PM, Staff C, Licensed Practical Nurse (LPN) stated the MD, family, and Assistant Director of Nursing (ADON) or Administrator On-Call (AOC) should be notified of newly identified resident skin wounds and get orders from the doctor. She also stated she didn't recall whether or not she contacted the MD or resident's family. On 8/07/25 at 12:21 PM, the Director of Nursing (DON) stated staff should have called the physician, gotten an order, started the order, documented it, and notified the family of the new order. In an email dated 8/07/25 at 1:24 PM, the Administrator indicated the facility follows the nursing standards of practice related to assessments.	F0684		
F0740 SS = J	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, facility self report, State of Iowa Administrative Hearings Findings, and staff interviews, the facility failed to perform behavioral health assessments for Resident #1 after he was served a 30 day involuntary discharge notice following an alleged assault on another resident. Resident #1 had a documented history of major depressive disorder and suicidal ideation and was placed on one to one (1:1) supervision after the alleged assault. On 7/24/25 the 1:1 supervision was discontinued to address a staffing shortage without Resident #1 being assessed. During the early morning hours of 7/25/25, with no 1:1 supervision, Resident #1 used items within reach and committed suicide hours before his scheduled discharge from the facility. The facility reported a census of 124 residents. On August 5, 2025 at 5:00 pm, the State Survey Agency	F0740		

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F0740 SS = J	Continued from page 13 informed the facility of the failure to perform behavioral health assessments following notification of an involuntary discharge created an Immediate Jeopardy situation, which resulted in the suicide of a resident. The Immediate Jeopardy began on July 24, 2025. The facility removed the immediacy on August 7, 2025 at 12:00 pm when the facility staff implemented the following Corrective Actions: Audits of all residents for Psychosocial History compliance Audits of all residents for a history of suicidal ideation or attemptsCreation and Implementation of a Suicide Prevention PolicyCreation and Implementation of a Phone Answering PolicyEducation to all employees of “Suicide in Older Adults”Education to all employees of “Recognizing Behavioral Symptoms in Residents at Risk for Self Harm”Education to all employees for “Clinical Procedure for Care of Residents with Depression” and “Assessing and Screening for Suicide Risk”Education to all employees of Resident RightsAudits of all residents behavior documentation for suicidal ideationsDiagnosis report for impulsivenessEducation to managerial staff of Behavior Interventions may only be changed/modified/discontinued by the Executive Director or the Director of NursingThe scope and severity lowered from a J to a G (harm that is not immediate) at the time of the survey after ensuring the facility implemented their policy and procedures, audits, and staff education. Findings include: The Minimum Data Set (MDS) of Resident #1 dated 6/4/25 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS recorded the resident experienced mood symptoms of feeling down, depressed, or hopeless on one day of the lookback period. The MDS recorded the resident dependent upon staff assistance for chair/bed-to-chair transfers. The MDS documented diagnoses that included: paraplegia, anxiety, depression, and alcohol abuse with alcohol-induced mood disorder. The Care Plan of Resident #1 identified a Focus Area of Mood Behavior, stating Resident #1 had a diagnosis of Major Depressive Disorder. It directed staff to perform BIMS and PHQ-9 (an assessment used to screen for and measure the severity of depression) upon admission, quarterly, annually and as needed and to notify the physician as needed with concerns. The Care Plan additionally directed staff to keep the resident’s routine the same as much as able and to offer opportunities for the resident to express feelings. The Care Plan additionally directed for social services to	F0740		

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F0740 SS = J	Continued from page 14 intervene as needed. The Care Plan identified an additional Focus Area of Abuse Vulnerability, history of suicide attempts. The Care Plan directed Staff to observe and provide a safe environment, staff to receive annual training and for Notifications to be made to Immediate Supervisor. The Facility Reported Incident (FRI) dated 6/30/25 documented that, on 6/30/25, Resident #3 reported to the facility chaplain that she had been physically assaulted by Resident #1 on 6/27/25. According to the FRI, Resident #1 had grabbed and squeezed the upper leg of Resident #3 while he was passing by her in his electric wheelchair. The facility immediately ensured separation of the two residents, assigning a 1:1 Certified Nursing Assistant (CNA) to supervise Resident #1 to maintain that separation. A skin assessment of Resident #3 revealed black and blue bruises consistent with her account of the incident. The Sheriff's Office was contacted and a police report was filed. In a discussion between Resident #1 and the Administrator, Resident #1 displayed an unprompted awareness of the identity of Resident #1. The facility initiated an emergency discharge of Resident #1, and an Emergency Notice of Involuntary Discharge was hand delivered to Resident #1 on 6/30/25. With the assistance of the facility's Social Services Director, Resident #1 filed an appeal to the discharge and a hearing took place on 7/15/25. On 8/7/25, the Director of Nursing (DON) stated that she and the Administrator together notified Resident #1 on 7/22/25 that the discharge had been upheld in the hearing and offered him assistance to file a second appeal. She stated Resident #1 declined her assistance, stating he was resigned to it that he was discharging, and asked for some boxes to pack his belongings. She stated he also requested the facility continue to work on finding alternate placement as another facility that had accepted him was not his first choice of places to transfer to. The DON clarified the resident had received this notice earlier but had failed to open the envelope which contained the findings of the hearing. The Facility Reported Incident (FRI) dated 7/25/25 documented that at approximately 5:30 am on 7/25/25, facility staff discovered Resident #1 deceased in his room following a successful suicide attempt. The FRI detailed Staff B, Registered Nurse (RN) was the night shift supervisor on duty. Staff A, Licensed Practical Nurse (LPN), MDS Coordinator, was on call for any staffing issues. On 7/24/25, two CNAs failed to report for their scheduled shift. Staff A notified Staff B per	F0740		

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F0740 SS = J	Continued from page 15 protocol. The FRI further stated that the two staff members developed a coverage plan to ensure sufficient staffing, which included removing the 1:1 supervision of Resident #1 so the assigned CNA could perform general floor duties. Resident #1 was checked on at least every two hours with no noted concerns during these checks until approximately 5:30 am. On this check, Resident #1 was found on the floor of his room, surrounded by blood. The attending nurse assessed and determined Resident #1 had used a piece of glass from a broken picture frame and a set of scissors to cut himself, severing an artery of his left arm, resulting in death. Staff immediately called 911 and required persons were notified of the incident. During a chart review on 8/7/25, the Care Plan of Resident #1 failed to reflect any status updates regarding the assault, the involuntary discharge, or the 1:1 supervision. The Progress Notes portion of the resident's Electronic Health Record (EHR) failed to reflect any progress notes that had been entered by either of the facility social services representatives. The EHR additionally failed to document any psychosocial assessments having been completed following the notice of involuntary discharge on 6/30/25. On 7/31/25 at 12:29 pm, Staff A, LPN, MDS Coordinator, stated she was on call the night of 7/24/25. She reported she was asleep when Staff B, RN, texted to inform her that two CNAs had not reported for work. Staff A stated she instructed Staff B to call both absent staff members, providing her with phone numbers, and advised her to ask 2pm-10pm shift staff if anyone could stay late to assist. Staff A stated Staff B asked if the 1:1 supervision of Resident #1 could be removed, and she responded that it was acceptable as long as the resident was asleep. She added that a second CNA from the Memory Care Unit (MCU) were also reassigned so that each unit had a CNA on duty. Staff A further stated that there were two additional nurses on duty that night, both in orientation, and therefore she believed there was adequate staffing in the building. Staff A verbalized she felt Staff B would move the available staff around to accommodate the staffing needs. She also added the 1:1 supervision was intended to keep Resident #1 separated from other residents, and noted that on the night shift the 1:1 often sat outside the door while he slept rather than remaining in his room. She added that if the supervision had been for suicide watch, the approach would have been different. On 7/31/25 at 5:15 pm, Staff B, RN stated her shift began at 6:00 pm on 7/24/25. She reported that,	F0740		

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F0740 SS = J	Continued from page 16 although her position was the night shift supervisor, she initially did not perform supervisory duties because she was covering for a nurse at 6:00 pm. Around 8:00 pm, a staffing agency nurse arrived, and from that time until approximately 10:00 pm, she resumed supervisory duties. At 10:00 pm, two CNAs failed to report for their shifts. After unsuccessfully attempting to contact them and asking on-duty staff to stay, she had contacted Staff A, the manager on call, and after informing her of the situation, requested the removal of the 1:1 supervision of Resident #1 as well as moving a second CNA from the MCU. Staff B stated she was aware Resident #1 was paralyzed, unable to get out of bed, and typically asleep by that time of night, which was why she requested the removal of the 1:1. She stated she returned to working the floor at 10:00 pm, and described the shift as busy. Staff B said that at approximately 5:30 am, she heard screaming from another area of the building. Following the sound, she heard staff calling her name regarding Resident #1. Upon entering his room, she observed the resident lying on the floor in a pool of blood. She directed another staff member to call 911, and she assessed the resident for a pulse and breathing, neither being present. Paramedics arrived quickly, and it was confirmed that Resident #1 had a do not resuscitate order; no CPR was performed. On 8/4/25 at 4:30 pm, the Social Services Director (SSD) stated she had helped Resident #1 file his appeal of the involuntary discharge. She stated she did not participate in the hearing regarding the discharge. The SSD stated she was on vacation from the 19th until the 23rd of July, returning to work on the 24th of July. Upon her return to work, she was informed the discharge was upheld and Resident #1 chose not to file a second appeal. She stated she went to his room to speak with him and told him she was sorry to hear about him losing his appeal and mentioned he would be transferring to another facility. She described Resident #1 would not make eye contact with her, although they normally had a good relationship. She stated she joked with him that at least at the other facility, he would be able to smoke and “not get in trouble for it”. When Resident #1 did not respond, she turned to leave, and Resident #1 stopped her and told her he did not want her to feel guilty about anything that happened, and that she had done all she could to help him. The SSD voiced that in hindsight, she felt this was a suicidal statement, but at the time he said it, she did not take it that way. The SSD also reported she had experience working a suicide hotline.	F0740		

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F0740 SS = J	Continued from page 17 The SSD stated the hearing regarding the involuntary discharge had taken place on 7/15/25 and when she had asked facility management if she was to participate in the hearing, she was told no. She explained after assisting him in filing the appeal, she had no further contact with Resident #1 until 7/24/25. She stated she works more with the skilled residents in the facility while the other social service representative worked more with the long term care residents. She added his PHQ-9 scores were always zero, indicating no depression, saying he never gave any inclination he was thinking of suicide. She added that while nobody anticipated suicide, more follow up probably should have been provided. She stated there were no protocols in place of daily check ins but reiterated Resident #1 was offered psychiatric services but he declined them. She explained these services were offered after the appeal hearing had taken place, after the ruling was given. She explained the services offered were virtual and the Assistant Director of Nursing (ADON) for his hallway had acomputer, and attempted to get him to participate in the therapy session but the ADON was unaware of why therapy sessions had been set up. Another ADON in the facility explained to the resident the reason for the services and the resident then declined the services. In a second interview on 8/5/25 at 10:59 am, Staff A clarified she did not give Staff B specific direction for staffing needs in regards to the two nurses who were orientating on the night shift of 7/24/25. She stated once she ok'd the removal of the 1:1 and the second CNA from the memory care unit, she assumed Staff B was taking care of the situation. She added she had worked the day shift on Wednesday 7/23/25 and then had to work the overnight shift as well. She got home around 7:00 am on 7/24/25. She stated she received copies of the schedule for 7/24/25 via text from the facility, looked at the schedule and felt they were fully staffed. She stated in her mind, due to the extra two nurses, they had enough staff. She verified no assessment was completed on Resident #1 prior to removing the 1:1. She stated the reason for this was he was in bed, and she knew staff often sat outside of the room. She felt if he was sleeping, there was no reason for a staff member to be sitting there. She clarified she is the MDS Coordinator, and not an ADON. She was aware the facility required that any staffing changes could only be made at the direction of the DON or an ADON. She stated she normally would call the DON but did not call her that night due to having extra nurses in orientation on duty. She reiterated if they had not been there, she would have come in.	F0740		

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F0740 SS = J	Continued from page 18 On 8/5/25 at 3:05 pm, Staff D, Social Services designee, stated she had only worked at the facility for a few months. She stated she and Resident #1 had gotten off on the wrong foot when she started due to her needing to speak to him about him driving his electric wheelchair too fast through the halls. She stated once during the appeal process, she checked in with Resident #1 but he had been speaking with someone from Medicaid. She described him as being very closed off when she checked in on him and state that was the only time she had any contact with him after the involuntary discharge notice was given other than briefly saying hello in passing. On 8/6/25 at 9:04 am, Staff E, LPN stated she was the nurse assigned to Resident #1's hallway on 7/24/25 for the overnight shift. She stated she had been a nurse for over 20 years but had worked at the facility for a short time. She explained she was assigned to that hallway, as well as the MCU, and additionally needed to help in the Assisted Living part of the facility to administer insulin and cover meal breaks. She was also orienting Staff F, LPN who was a new nurse. She explained it was a very busy shift, and a new resident in the MCU unit was upset and exit seeking and setting off alarms much of the shift. She stated she did not see Resident #1 that shift until the morning. She stated she works throughout the building and did not know Resident #1 well. She added with the staffing pattern of most employees working in multiple areas of the building, she is unable to get to know the residents well or build rapport with them. She felt if she had known Resident #1 better, perhaps he would have confided in her as she had worked with other suicidal patients in the past and had been able to assist. She stated staff F, LPN administered insulin for Resident #1 that shift, and the Medication Aide administered his oral medications. She was aware that Resident #1 was under 1:1 supervision and the reason for the supervision. She stated no staff had informed her the 1:1 person had been removed from his room. She said that to her knowledge, Resident #1 had no prior suicidal ideations. When Staff E was told prior suicide attempt was included on the Resident Care Plan, she stated she is not familiar with the software program the facility uses for the resident's Electronic Health Records and did not know how to retrieve or read a resident care plan. On 8/6/24 at 10:18 am. Staff F, LPN stated she worked at the facility earlier in the summer as a CNA. She had recently passed the State Boards and obtained her LPN license, and was then training as an LPN. She stated she trained with Staff E on her shift on 7/24/25. She	F0740		

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F0740 SS = J	Continued from page 19 stated the only interaction she had with Resident #1 during that shift was approximately 9:30 or 9:45 pm when she administered his night time insulin. She stated the Medication Aide had administered his oral medication. She had been told Resident #1 often refused his nightly scheduled catheter flush, and he did refuse it that night. She stated she attempted to make some small talk with the resident when she was in the room with him, but he only responded with one word answers. She stated she was aware that there had been a CNA removed from the MCU to cover staffing needs but was not aware the 1:1 supervision had been removed from Resident #1. She said some staff sat in his room with him at night and others sat in the hallway. She verified after 10:00 pm, she had not been back in Resident #1's room. The Fire Department Patient Care record dated 7/25/25 recording the following: Squad 3** responded. Crew was met at the front door by nursing home staff. Staff reported patient was on the *** hallway. Staff reported the patient was a Do Not Resuscitate but this was an unusual instance so they called 911. On arrival to the room, the patient was found on the floor in a large pool of blood. It was noted blood was found all over the room also. Night shift lead nurse was in the room crying. She reported they came into the room and found the patient like this. Staff was not able to provide a last known well time for the crew. It was noted that there was obvious death. The patient was not breathing and had no pulse. Noted that there was a small pair of scissors (with blood on them) on a table and broken glass on the bed. The patient was not disturbed by the EMS crew, no EMS interventions were taken. Crew was able to see multiple cuts to the left wrist from the doorway with a large pool of blood coming from cut site. Nursing home staff reported that the notes taped on the window and refrigerator door appear to be new. They state "Thank you Railroad (female name). Crew removed all staff from the room at this time. The Medical Examiner and sheriff's office were called to the scene. While getting information from the staff, it was reported the patient was leaving the facility that day. Staff was able to provide a current DNR status and a face sheet. On arrival of the Sheriff's Office, crew explained the circumstances they walked into. No further actions were taken. The scene was turned over to the Sheriff's Office. On 8/4/25, the DON stated no staff called her the night of 7/24/25. She stated that Staff F, LPN had been a CNA prior to becoming an LPN and she could have been pulled	F0740		

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F0740 SS = J	Continued from page 20 to sit with Resident #1 that night. She stated if staff had called her, that would have been her directive, to not remove the 1:1 but to have Staff F act as the 1:1. In an email dated 8/07/25 at 1:24 PM, the Administrator indicated the facility follows the nursing standards of practice related to assessments.	F0740		
F0741 SS = J	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.71. These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.71, and §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, facility self report, State of Iowa Administrative Hearings Findings, staff and family interviews, and facility policy review, the facility failed to recognize and address potential statements and behaviors that indicated Resident #1's self harm risk after he was served a 30 day involuntary discharge notice following an alleged assault on another resident. Resident #1 had a documented history of major depressive disorder and suicidal ideation and was placed on one to one (1:1) supervision after the alleged assault. In the days leading up to his discharge, multiple staff members stated they observed Resident #1's potential signs of worsening depression or heard him verbalize comments of potential self-harm but did not report these concerns to facility	F0741		

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(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
F0741 SS = J	Continued from page 21 management. During the early morning hours of 7/25/25, without 1:1 supervision in place, Resident #1 used items within reach and committed suicide hours before his scheduled discharge from the facility. The facility reported a census of 124 residents. On August 5, 2025 at 5:00 pm, the State Survey Agency informed the facility the staff failure to recognize, address and report potential statements and behaviors of self-harm following the notification of an involuntary discharge created an Immediate Jeopardy situation, which resulted in the suicide of a resident. The Immediate Jeopardy began on July 24, 2025 The facility removed the immediacy on August 7, 2025 at 12:00 pm when the facility staff implemented the following Corrective Actions: Audits of all residents for Psychosocial History compliance Audits of all residents for a history of suicidal ideation or attemptsCreation and Implementation of a Suicide Prevention PolicyCreation and Implementation of a Phone Answering PolicyEducation to all employees of “Suicide in Older Adults”Education to all employees of “Recognizing Behavioral Symptoms in Residents at Risk for Self Harm”Education to all employees for “Clinical Procedure for Care of Residents with Depression” and “Assessing and Screening for Suicide Risk”Education to all employees of Resident RightsAudits of all residents behavior documentation for suicidal ideationsDiagnosis report for impulsivenessEducation to managerial staff of Behavior Interventions may only be changed/modified/discontinued by the Executive Director or the Director of NursingThe scope and severity lowered from a J to a G (harm that is not immediate) at the time of the survey after ensuring the facility implemented their policy and procedures, audits, and staff education. Findings include: The Minimum Data Set (MDS) of Resident #1 dated 6/4/25 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS recorded the resident experienced mood symptoms of feeling down, depressed, or hopeless on one day of the lookback period. The MDS recorded the resident dependent upon staff assistance for chair/bed-to-chair transfers. The MDS documented diagnoses that included: paraplegia, anxiety, depression, and alcohol abuse with alcohol-induced mood disorder. The Care Plan of Resident #1 identified a Focus Area of Mood Behavior, stating Resident #1 had a diagnosis of Major Depressive Disorder. It directed staff to perform BIMS and PHQ-9 (an assessment used to screen for and	F0741		

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F0741 SS = J	Continued from page 22 measure the severity of depression) upon admission, quarterly, annually and as needed and to notify the physician as needed with concerns. The Care Plan additionally directed staff to keep the resident's routine the same as much as able and to offer opportunities for the resident to express feelings. The Care Plan additionally directed for social services to intervene as needed. The Care Plan identified an additional Focus Area of Abuse Vulnerability, history of suicide attempts. The Care Plan directed Staff to observe and provide a safe environment, staff to receive annual training and for Notifications to be made to Immediate Supervisor. The Facility Reported Incident (FRI) dated 6/30/25 documented that, on 6/30/25, Resident #3 reported to the facility chaplain that she had been physically assaulted by Resident #1 on 6/27/25. According to the FRI, Resident #1 had grabbed and squeezed the upper leg of Resident #3 while he was passing by her in his electric wheelchair. The facility immediately ensured separation of the two residents, assigning a 1:1 Certified Nursing Assistant (CNA) to supervise Resident #1 to maintain that separation. A skin assessment of Resident #3 revealed black and blue bruises consistent with her account of the incident. The Sheriff's Office was contacted and a police report was filed. In a discussion between Resident #1 and the Administrator, Resident #1 displayed an unprompted awareness of the identity of Resident #1. The facility initiated an emergency discharge of Resident #1, and an Emergency Notice of Involuntary Discharge was hand delivered to Resident #1 on 6/30/25. With the assistance of the facility's Social Services Director, Resident #1 filed an appeal to the discharge and a hearing took place on 7/15/25. On 8/7/25, the Director of Nursing (DON) stated that she and the Administrator together notified Resident #1 on 7/22/25 that the discharge had been upheld in the hearing and offered him assistance to file a second appeal. She stated Resident #1 declined her assistance, stating he was resigned to it that he was discharging, and asked for some boxes to pack his belongings. She stated he also requested the facility continue to work on finding alternate placement as another facility that had accepted him was not his first choice of places to transfer to. The DON clarified the resident had received this notice earlier but had failed to open the envelope which contained the findings of the hearing. The Facility Reported Incident (FRI) dated 7/25/25 documented that at approximately 5:30 am on 7/25/25,	F0741		

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F0741 SS = J	Continued from page 23 facility staff discovered Resident #1 deceased in his room following a successful suicide attempt. The FRI detailed Staff B, Registered Nurse (RN) was the night shift supervisor on duty. Staff A, Licensed Practical Nurse (LPN), MDS Coordinator, was on call for any staffing issues. On 7/24/25, two CNAs failed to report for their scheduled shift. Staff A notified Staff B per protocol. The FRI further stated that the two staff members developed a coverage plan to ensure sufficient staffing, which included removing the 1:1 supervision of Resident #1 so the assigned CNA could perform general floor duties. Resident #1 was checked on at least every two hours with no noted concerns during these checks until approximately 5:30 am. On this check, Resident #1 was found on the floor of his room, surrounded by blood. The attending nurse assessed and determined Resident #1 had used a piece of glass from a broken picture frame and a set of scissors to cut himself, severing an artery of his left arm, resulting in death. Staff immediately called 911 and required persons were notified of the incident. In the follow up investigation of the incident, the facility stated during the investigation, it was discovered a voicemail had been left on an unattended facility phone. To ensure emergency response protocols, the facility implemented a new policy to address that issue. The follow up further stated the decision to reassign the 1:1 CNA was made by Staff A and Staff B without reporting to or obtaining permission from the DON, as required by facility policy. Using the facility's Just Culture Algorithm, it was determined that this constituted a change due to failure to report and request approval from their supervisor for the staffing change. Both staff members received a suspension. On 7/31/25 at 12:29 pm, Staff A, LPN, MDS Coordinator stated she was on call the night of 7/24/25. She reported she was asleep when Staff B, RN, texted to inform her that two CNAs had not reported for work. Staff A stated she instructed Staff B to call both absent staff members, providing her with phone numbers, and advised her to ask 2pm-10pm shift staff if anyone could stay late to assist. Staff A stated Staff B asked if the 1:1 supervision of Resident #1 could be removed, and she responded that it was acceptable as long as the resident was asleep. She added that a second CNA from the Memory Care Unit (MCU) were also reassigned so that each unit had a CNA on duty. Staff A further stated that there were two additional nurses on duty that night, both in orientation, and therefore she believed there was adequate staffing in the building. Staff A verbalized she felt Staff B would move the available	F0741		

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F0741 SS = J	Continued from page 24 staff around to accommodate the staffing needs. She also added the 1:1 supervision was intended to keep Resident #1 separated from other residents, and noted that on the night shift the 1:1 often sat outside the door while he slept rather than remaining in his room. She added that if the supervision had been for suicide watch, the approach would have been different. On 7/31/25 at 1:10 pm, Staff G, Certified Nurse Aide (CNA) stated she acted as the 1:1 on the 2:00 pm to 10:00 pm shift on 7/24/25. She stated Resident #1 was making a lot of phone calls. She stated she was in the room with him for part of the shift and sitting in the hallway for part of the shift. She stated she thought one of the phone calls he had made had been to a bank. She overheard him stating he wanted money to go to his nephew “if anything were to happen to him”. She stated otherwise he was acting normal and she did not think anything of the statement. She said she had only been employed at the facility for a month or so and this was her first job as a CNA and she did not know Resident #1 well. She stated after she was sitting in the hallway, she overheard him talking and initially thought he was speaking to her. She stepped into the room and heard him on the phone so she stepped back into the hallway and was relieved by another staff member at 10:00 pm. On 7/31/25 at 1:55 pm, Staff H, CNA stated she worked with Resident #1 for a short time on 7/24/25 on the 2-10 shift, when Staff G was on break. She stated Resident #1 asked her to take him outside to smoke, so they went to the far end of the building outdoors and he smoked and then she assisted him back to his room. She stated Resident #1 had been acting depressed for several days. She said once the judgement came back that he had to move out, she knew there was nothing anyone could do about it. She stated she did not bring any concerns of his depression forward to any management or the social worker. She stated everyone knew how depressed he was, all the nurses on the floor, etc. She stated anybody who worked that hallway knew he was depressed. Staff H said she had worked at the facility for several years and knew Resident #1 pretty well. She stated he was very quiet and seemed down, but she had no idea he was contemplating suicide. She stated if she had any idea, she would have reported it and felt any other staff member would have as well. On 7/31/25 at 5:15 pm, Staff B, RN stated her shift began at 6:00 pm on 7/24/25. She reported that, although her position was the night shift supervisor, she initially did not perform supervisory duties because she was covering for a nurse at 6:00 pm. Around 8:00 pm, a staffing agency nurse arrived, and from that	F0741		

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F0741 SS = J	Continued from page 25 time until approximately 10:00 pm, she resumed supervisory duties. At 10:00 pm, two CNAs failed to report for their shifts. After unsuccessfully attempting to contact them and asking on-duty staff to stay, she had contacted Staff A, the manager on call, and after informing her of the situation, requested the removal of the 1:1 supervision of Resident #1 as well as moving a second CNA from the MCU. Staff B stated she was aware Resident #1 was paralyzed, unable to get out of bed, and typically asleep by that time of night, which was why she requested the removal of the 1:1. She stated she returned to working the floor at 10:00 pm, and described the shift as busy. Staff B said that at approximately 5:30 am, she heard screaming from another area of the building. Following the sound, she heard staff calling her name regarding Resident #1. Upon entering his room, she observed the resident lying on the floor in a pool of blood. She directed another staff member to call 911, and she assessed the resident for a pulse and breathing, neither being present. Paramedics arrived quickly, and it was confirmed that Resident #1 had a do not resuscitate order; no CPR was performed. On 8/1/25 at 11:28 am, Staff I, CNA stated she was working the overnight shift on Resident #1's hallway on 7/24/25. She stated she was the one who found him deceased. She stated that around 10:30 or maybe 11:00 pm, the 1:1 was pulled from Resident #1. She stated she was working the floor, following her normal routine. She thought it was around 1:00 am when she checked on him and asked him how he was doing. She stated she completed some charting and then around 2:00 am began her rounding again. She stated she checked on him again during that set of rounds and he was watching TV at that time. She stated at approximately 4:00 am, there was another resident on the same hall who needed to be woken up and gotten ready to go to dialysis. She made a light breakfast for that resident and made sure she ate. She said that around 4:15 she got the resident dressed and then about 4:30 she transported that resident to the front of the building to be picked up for dialysis and then went to do rounds again. She stated she checked on Resident #1 again during these rounds. Following the completion of her rounds, she stated she then needed to empty catheters for the applicable residents. Resident #1 had a catheter. She stated it was around 5:15 or 5:30 when she entered his room to empty his catheter and found him on the floor in a pool of blood and called for help. Staff I stated she knew Resident #1 pretty well. She added that when they found out he had to move out, many staff were upset about it. She said she didn't think he	F0741		

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F0741 SS = J	Continued from page 26 had done it (the assault). She explained that night, when she asked him how he was doing, he replied he was “saying his good-byes”. She expressed she should have known, when he said that, that something was wrong. She said she just keeps thinking about it. But he was moving to another facility. She stated she was not aware that anyone had reported any concerns to management of his depression. On 8/4/25 at 4:30 pm, the Social Services Director (SSD) stated she had helped Resident #1 file his appeal of the involuntary discharge. She stated she did not participate in the hearing regarding the discharge. The SSD stated she was on vacation from the 19th until the 23rd of July, returning to work on the 24th of July. Upon her return to work, she was informed the discharge was upheld and Resident #1 chose not to file a second appeal. She stated she went to his room to speak with him and told him she was sorry to hear about him losing his appeal and mentioned he would be transferring to another facility. She described Resident #1 would not make eye contact with her, although they normally had a good relationship. She stated she joked with him that at least at the other facility, he would be able to smoke and “not get in trouble for it”. When Resident #1 did not respond, she turned to leave, and Resident #1 stopped her and told her he did not want her to feel guilty about anything that happened, and that she had done all she could to help him. The SSD voiced that in hindsight, she felt this was a suicidal statement, but at the time he said it, she did not take it that way. The SSD also reported she had experience working a suicide hotline. The SSD stated the hearing regarding the involuntary discharge had taken place on 7/15/25 and when she had asked facility management if she was to participate in the hearing, she was told no. She explained after assisting him in filing the appeal, she had no further contact with Resident #1 until 7/24/25. She stated she works more with the skilled residents in the facility while the other social service representative worked more with the long term care residents. She added his PHQ-9 scores were always zero, indicating no depression, saying he never gave any inclination he was thinking of suicide. She added that while nobody anticipated suicide, more follow up probably should have been provided. She stated there were no protocols in place of daily check ins but reiterated Resident #1 was offered psychiatric services but he declined them. She explained these services were offered after the appeal hearing had taken place, after the ruling was given. She explained the services offered were virtual and the Assistant Director of Nursing (ADON) for his	F0741		

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F0741 SS = J	Continued from page 27 hallway with a computer, attempting to get him to participate in the therapy session but was unaware of why therapy sessions had been set up. Another ADON in the facility explained to the resident the reason for the services and the resident then declined the services. On 8/4/25 at 4:47 pm, the DON stated that Staff F, LPN, who was in orientation that night, could have been pulled to be the 1:1 as she had worked as a CNA prior to becoming a nurse. She stated she didn't receive a phone call that night and that would have been her directive if anyone had called her. In regards to the referenced voicemail, she stated each hall of the facility has it's own cell phone that connects to the land lines. She stated after hours, there are prompts to be connected to the hall a person is trying to reach. She said on the night shift, the nurses generally only carry one phone, although they are covering more than one hall as a nurse. She said for instance, on night shift, there is one nurse who covers both the 300 hall and the 500 hall, but may only carry one of those two phones. She stated they found the voicemail on the phone of the hall where Resident #1 resided. She said the family member who left the voicemail also had her own personal cell phone number but she didn't call her, or the police or anyone else that she was aware of. She said when she called the family member the following morning to inform her of Resident #1's death, the family member stated she had left a voicemail the night before. In a second interview on 8/5/25 at 10:59 am, Staff A, LPN, MDS Coordinator clarified she did not give Staff B specific direction for staffing needs in regards to the two nurses who were orientating on the night shift of 7/24/25. She stated once she ok'd the removal of the 1:1 and the second CNA from the memory care unit, she assumed Staff B was taking care of the situation. She added she had worked the day shift on Wednesday 7/23/25 and then had to work the overnight shift as well. She got home around 7:00 am on 7/24/25. She stated she received copies of the schedule for 7/24/25 via text from the facility, looked at the schedule and felt they were fully staffed. She stated in her mind, due to the extra two nurses, they had enough staff. She verified no assessment was completed on Resident #1 prior to removing the 1:1. She stated the reason for this was he was in bed, and she knew staff often sat outside of the room. She felt if he was sleeping, there was no reason for a staff member to be sitting there. She clarified she is the MDS Coordinator, and not an ADON. She was aware the facility required staffing changes could only be made at the direction of the DON or an ADON. She	F0741		

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F0741 SS = J	Continued from page 28 stated she normally would call the DON but did not call her that night due to having extra nurses in orientation on duty. She reiterated if they had not been there, she would have come in. On 8/5/25 at 11:17 am, Staff J, RN stated she had worked at the facility for several months. She stated she did not notice a big mood change in Resident #1, but noted he was more quiet. She said right after the allegations of the assault were made against him, she specifically asked him if he had thoughts of suicide. She stated she asked him this because he seemed especially down that day. She said he denied it and laughed and said he would never do that. She said she did not work with him the week of 7/21/25. On 8/5/25 at 11:37 am, Staff K, CNA stated she had been currently working at the facility for about one and a half years, but had also worked her prior and left. She stated she knew Resident #1 well and used to take care of him when he previously lived on another hall of the facility. She said she worked with him nearly every day she was scheduled to work. She described him as being down in the dumps over the last few weeks. She said he was very quiet. She said she occasionally acted as the 1:1 CNA and escorted him on a shopping trip on the local bus. She said recently, he was using his tablet more, and was not as talkative. She said prior to this, he would come to eat in the dining room and roam all over the facility. She said some mornings, she noticed the night shift 1:1 were sitting outside in the hallway with his door shut when she came on shift. She said in her opinion, they needed to be in the room with him but understood he also liked his privacy. She said she often assisted a second staff member to use the full body mechanical lift to transfer from his bed to his chair in the mornings, and he just seemed down. He used to visit with other male residents at meals before he was notified of needing to move out. She said she had noticed recently when it was time for his insulin, he would just park his chair near the medication cart, and sit with his head down and wait for the insulin then go back to his room. She said the nurses were aware of his behaviors, everybody could see it. On 8/5/25 at 11:45 am, Staff L, Certified Medication Aide (CMA) stated Resident #1 seemed a bit depressed. She said she didn't work his area of the building too often, and in his last week, she maybe only saw him once. She said he just seemed different. He used to be more bubbly, talking to everyone. Then he started staying in his room, not talking as much. She said it was out of the ordinary but she hadn't felt it was alarming.	F0741		

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F0741 SS = J	Continued from page 29 On 8/5/25 at 11:47 am, Staff M, CNA stated she had sat with him 1:1 a couple of days earlier in the week before the incident. She said he was very quiet. After he was dressed and out of bed, he asked her to just sit in the room and watch TV. She said they left the room once, he wanted to speak with the DON about his leaving. He was telling her he didn't want to go to the facility that had accepted him. There was another facility he wanted to go to instead. She said she asked him if he was nervous and he stated no, he just wanted to go to an alternate facility. She stated he was back in his room at the end of her shift, and just seemed quieter than usual. On 8/5/25 at 1:57 pm, Staff N, CNA stated she was scheduled to be the 1:1 on the 10:00 pm to 6:00 am shift on 724/25. She stated she was with him for approximately 45 minutes to an hour when she was pulled to work the floor in another area of the facility. She stated she looked in on him and he was watching TV and she sat in the hallway and had no interaction with him. She was not aware of any changes in him. On 8/5/25 at 3:05 pm, Staff D, Social Services designee, stated she had only worked at the facility for a few months. She stated she and Resident #1 had gotten off on the wrong foot when she started due to her needing to speak to him about him driving his electric wheelchair too fast through the halls. She stated once during the appeal process, she checked in with Resident #1 but he had been speaking with someone from Medicaid. She described him as being very closed off when she checked in and that was the only time she made contact with him other than saying hello in the hallways. On 8/6/25 at 9:04 am, Staff E, LPN stated she was the nurse assigned to Resident #1's hallway on 7/24/25 for the overnight shift. She stated she had been a nurse for over 20 years but had worked at the facility for a short time. She explained she was assigned to that hallway, as well as the MCU, and additionally needed to help in the Assisted Living part of the facility to administer insulin and cover meal breaks. She was also orienting Staff F, LPN who was a new nurse. She explained it was a very busy shift, and a new resident in the MCU was upset and exit seeking and setting off alarms much of the shift. She stated she did not see Resident #1 that shift until the morning. She stated she works throughout the building and did not know Resident #1 well. She added with the staffing pattern of most employees working in multiple areas of the building, she is unable to get to know the residents	F0741		

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F0741 SS = J	Continued from page 30 well or build rapport with them. She felt if she had known Resident #1 better, perhaps he would have confided in her as she had worked with other suicidal patients in the past and had been able to assist. She stated staff F, LPN administered insulin for Resident #1 that shift, and the Medication Aide administered his oral medications. She was aware that Resident #1 was under 1:1 supervision and the reason for the supervision. She stated no staff had informed her the 1:1 person had been removed from his room. She said that to her knowledge, Resident #1 had no prior suicidal ideations. When Staff E was told prior suicide attempt was included on the Resident Care Plan, she stated she is not familiar with the software program the facility uses for the resident's Electronic Health Records and did not know how to retrieve or read a resident care plan. Staff E Stated that Staff I, CMA had the phones prior to 10:00 pm as she was passing medications. She said at 10:00 pm, she thought that Staff F had the phones but she did not remember for sure. She said she had difficulty with the phones on prior shifts, she would find a "Missed Call" notification without the phone ever ringing. She said she would find the ringer volume was turned off but felt it could have been accidental that it got turned off based on the style of the phone and where the ringer switch is. She also stated she was not aware of how to listen to voicemails on the phones as the phones require a code to get into them and she doesn't know the codes. She said one phone in the facility has the code written on the back of the phone but the other ones do not. She said the normal routine for her was to carry both phones, but she did not have them that night as she was orienting another nurse. On 8/6/24 at 10:18 am, Staff F, LPN stated she worked at the facility earlier in the summer as a CNA. She had recently passed the State Boards and obtained her LPN license, and was then training as an LPN. She stated she trained with Staff E on her shift on 7/24/25. She stated the only interaction she had with Resident #1 during that shift was approximately 9:30 or 9:45 pm when she administered his night time insulin. She stated the Medication Aide had administered his oral medication. She had been told Resident #1 often refused his nightly scheduled catheter flush, and he did refuse it that night. She stated she attempted to make some small talk with the resident when she was in the room with him, but he only responded with one word answers. She stated she was aware that there had been a CNA removed from the MCU unit to cover staffing needs but was not aware the 1:1 supervision had been removed from Resident #1. She said some staff sat in his room with him at night and others sat in the hallway. She	F0741		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN LIVING SENIOR CAMPUS	2421 LUTHERAN DRIVE , MUSCATINE, Iowa, 52761

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F0741 SS = J	Continued from page 31 verified after 10:00 pm, she had not been back in Resident #1's room. Staff F stated after 10:00 pm, she had both sets of keys (to the medication carts) and was given the phone to the MCU. She stated she did not have the phone for the hallway Resident #1 was on. She voiced she did know how to listen to voicemails on the facility phones but she didn't have that phone. On 8/6/25 at 1:18 pm, a family member of Resident #1 stated their family members all had apps on their phones they used to communicate with each other. She stated on the night of 7/24/25, Resident #1 had sent a message on the app "It's check out time". She stated she did not think anything of it but another family member contacted her and stated she felt that meant he was thinking of suicide. She stated she called the facility but the phone rang to voicemail. She left a voicemail asking staff to keep an eye on him. She stated she had not had direct contact with Resident #1 for some time as he had asked her to sign some paperwork for him regarding something to do with his wheelchair. She had refused to sign the paperwork and he had been angry with her. She said after she called the facility and left the voicemail, she went to sleep. She received a phone call the next morning telling her he had committed suicide. She said he was supposed to be under 24 hour surveillance. She said from what she had heard, the facility was short staffed and they had nobody to watch him. She said she didn't know if Resident #1 knew they were short staffed when he killed himself. She stated maybe if he had surveillance, they could have saved his life. She added if they had just listened to his voicemail, that could have saved his life. On 8/6/25 at 1:42 pm, Staff O, CNA stated she had worked at the facility for a couple of years. She stated she most often worked on the skilled unit, but Resident #1 came down to visit that part of the building almost daily. She said she last saw him the day before the incident and told him that he looked nice. She said he replied to her that looking nice was only on the outside, not the inside. She stated she asked him if he was ok and he replied he was fine but the whole situation was off. She said she asked him again if he was ok and told him she would talk to him more the next day and he replied ok. She told him she would "see him tomorrow" and he replied the same. On 8/6/25 at 2:10 pm, Staff D, Social Services designee, stated her normal routine is to complete the PHQ-9 on residents and the BIMS assessment. She stated there is also a trauma assessment available that is specific to residents who have a history of trauma, but	F0741		

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F0741 SS = J	Continued from page 32 she had never used that assessment. She said the normal routine is only to do these assessments during the MDS period. On 8/6/25 at 2:55 pm, Staff P, ADON for the hall Resident #1 resided on, stated she had been the ADON for a few months. Prior to that, she worked at the facility for several years but didn't know Resident #1 well. She said she would see him around as he was very mobile through the facility. She said she had not had any conversations with him regarding his discharge and that no staff had brought any concerns to her regarding him. She said if staff had any concerns they should report it to the charge nurse and the charge nurse should report it to her. She said she had attempted to assist him in the virtual therapy sessions but he refused to participate. The Fire Department Patient Care record dated 7/25/25 recording the following: Squad 3** responded. Crew was met at the front door by nursing home staff. Staff reported patient was on the *** hallway. Staff reported the patient was a Do Not Resuscitate but this was an unusual instance so they called 911. On arrival to the room, the patient was found on the floor in a large pool of blood. It was noted blood was found all over the room also. Night shift lead nurse was in the room crying. She reported they came into the room and found the patient like this. Staff was not able to provide a last known well time for the crew. It was noted that there was obvious death. The patient was not breathing and had no pulse. Noted that there was a small pair of scissors (with blood on them) on a table and broken glass on the bed. The patient was not disturbed by the EMS crew, no EMS interventions were taken. Crew was able to see multiple cuts to the left wrist from the doorway with a large pool of blood coming from cut site. Nursing home staff reported that the notes taped on the window and refrigerator door appear to be new. They state "Thank you Railroad (female name). Crew removed all staff from the room at this time. The Medical Examiner and sheriff's office were called to the scene. While getting information from the staff, it was reported the patient was leaving the facility that day. Staff was able to provide a current DNR status and a face sheet. On arrival of the Sheriff's Office, crew explained the circumstances they walked into. No further actions were taken. The scene was turned over to the Sheriff's Office. The Team Member Performance Improvement Plan (PIP) dated 7/30/25 for Staff A, MDS Coordinator, LPN documented:	F0741		

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F0741 SS = J	Continued from page 33 In reference to the incident that took place on 7/24-7/25/25. There was a decision made to pull a CNA from 1 on 1 status to help cover the floor for a suspected hole in coverage. This was a collaborated decision with Staff B, RN, but as the supervisor on duty, it should have been known that other options for coverage existed and were exhausted prior to disrupting a directed status of a 1 on 1 employee. Based on this it was determined that the On call process was not followed. The PIP further documented the Manager's Expectations as the following: All on call personnel take responsibility for knowing how the staffing looks prior to any shift and have developed a rough plan on how holes will be covered if they were to develop. Attempt to take a proactive approach to On call as a more operational roll instead of a recovery roll. Know or develop the options for coverage prior to the occurrence of failure, what backups are there? Who is able to come in? How can we move around? DO I NEED TO COME IN? Do not deviate from prior directives and if the only option is to deviate, contact DON (by phone only) for approval. The PIP dated 7/30/25 for Staff B was similarly worded, stating it should have been known as the nursing supervisor that other options for coverage existed and were exhausted prior to disrupting a directed status of a 1 on 1 employee. The facility policy titled On-Call Policy, Effective date of 1/1/2025 documented the following under Procedures:Single Call-Off:In the event of a staff call-off, the designated on-call nurse will:Develop an effective coverage plan within 30 minutes, which may include redistributing staff assignments, utilizing per diem staff, or coordinating with agency personnel.If no coverage is secured, the on-call nurse will report to the facility to cover the shift themselves.The on-call nurse will document the call-off and coverage plan in the staffing log, notifying the Director of Nursing (DON) or designee within one hour.Multiple Call-Offs:If multiple staff call-offs occur for a single shift, the on-call nurse will activate the facility's phone tree system to contact additional on-call nurses.Available on-call nurses are required to report to the facility to cover the affected shifts, prioritizing resident care areas based on acuity and regulatory requirements.The on-call nurse will coordinate with the Assistant Director of Nursing (ADON) to ensure all shifts are covered, with updates provided to the DON or designee.Emergency Situations:In an emergency situation (e.g., widespread staffing shortages or critical	F0741		

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F0741 SS = J	Continued from page 34 resident care needs), the ADON will consult with the DON or their designated representative to:Assess the situation and prioritize staffing needs.Implement contingency plans, such as temporary reassignment of non-clinical staff or expedited agency staffing requests.The ADON will document all actions taken and report to the DON within 24 hours for review and follow-up.	F0741		