STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165135	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Strawberry Point Lutheran Home	313 Elkader Street Strawberry Point, IA 52076

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20331 Based on staff interviews,review of clinical records, and facility policy review, the facility failed to provide assessment and intervention in a timely manner when one of three residents reviewed had a change in condition. (Resident #1). The facility reported a census of 13 residents. Findings include: The MDS (Minimum Data Set), an assessment tool dated 12/24/2024 revealed Resident #1 had diagnoses including renal insufficiency, post traumatic stress disorder, cancer, medically complex condition, anemia, and heart failure. The resident had no cognitive impairment and required partial assistance to transfer and used a wheel chair for locomotion. The resident's Care Plan initiated 10/13/2024 indicated the resident had impaired physical mobility with an unavoidable end of life decline, and he required total staff assistance to transfer using a mechanical lift initiated 1/8/2025. It revealed the resident received St Croix Hospice Services due to terminal prognosis. It failed to address the resident's cholecystostomy tube (a drainage tube inserted into the bile duct). The resident's Physician's Orders dated 11/11/2024 directed staff to change the cholecystostomy dressing every Monday, Wednesday, and Friday, cleanse the area with soap and water, and apply a cholecystostomy dressing and Tegaderm (a clear dressing). The orders also included directions to flush the cholecystostomy tube with 10 cc (cubic centimeters) of saline on Monday, Wednesday, and Friday. The January, 2025 TAR (Treatment Administration Record) revealed staff changed the cholecystostomy dressing on 1/20/2025. On 1/22/2025 the TAR revealed staff failed to provide the treatment due to not available. The Progress Notes dated 1/22/2025 at 10:29 A.M. reported the resident transferred to the Veteran's hospital via ambulance when finding the cholecystostomy drain not in place. The physician, hospice, and family were notified. At 9:48 A.M. staff found the resident with an intact cholecystostomy dressing, but no drain. At 1:55 P.M. the hospital notified the facility the resident would be returning after being advised to follow up with a surgical consult, and no current acute concerns. The resident arrived at 5:20 P.M. with no orders and no cholecystostomy bag. The resident's January, 2025 Progress Notes failed to include documentation related to when or how the cholecystostomy tube became dislodged. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/2025 at 1:30 P.M. the resident's physician reported the resident had several health issues that were terminal including necrotic tissue. The cholecystostomy tube re-insertion required surgical intervention and it had been discussed. The removal of the tube may have contributed to his demise, however he had been declining due to Kennedy ulcers (end of life wounds due to skin failure), infection, and congestive heart failure. The resident received hospice services. On 2/3/25 at 12:54 P.M., Staff B, Administrator reported on 1/22/2025 at around 8:00 A.M., Staff C., ADON (Assistant Director of Nursing) revealed Resident #1's chole (cholecystostomy) tubing was not in place. Hospice gave him the choice and he decided to go to the hospital. Staff D, night nurse revealed at around 4:00 A.M. she noticed the line was out and assumed it was discontinued. She observed the bag attached to the bed rail and the tubing next to the resident. Staff were re-educated regarding alerting staff. Staff E, DON (Director of Nursing) educated staff regarding what to assess for anytime there is an external line and when to notify the DON. Staff failed to document in the Progress Notes and notify management when they found the resident's drainage tube had become dislodged. On 2/3/2025 at 1:10 A.M., Staff E, DON reported the resident had CHF (Congestive Heart Failure), very poor circulation, edema and swelling in his legs. At 3:00 P.M., Staff E stated the resident should have been Care Planned for the cholecystostomy tube. Staff were educated regarding assessment and intervention. On 2/3/2025 at 1:35 P.M. Staff C, ADON reported on 1/22/2025, she assisted Staff A with the resident's treatments when they observed the resident's chole tubing was not in place. The administrator and DON were notified and they began an investigation. The Progress Notes had no documentation regarding the removal of the tubing. The resident's Care Plan should have addressed the chole tubing as well. Staff received education regarding notification of the physician and administration when a resident has a change in condition. On 2/3/2025 at 10:15 A.M., Staff A, RN revealed on 1/22/2025 she found the resident's cholecystostomy tube had been removed. Staff A revealed the resident's Progress Notes failed to document when or how the tubing was removed. Staff A received no verbal report regarding the removal of the tube. The hospital did not admit the resident, they encouraged him to get a surgical consult, re-inserting the tubing required anesthesia and surgery and the resident was not a candidate. Staff A learned during the investigation that staff found the tubing in bed, near the resident during the night. The Internal Investigation dated 1/22/2025 included: at 8:38 A.M. the ADON and nurse provided cares and noted the cholecystostomy tubing and bag was not in place, and the area had been covered with a dressing. Staff D, LPN stated around 4 o'clock A.M. on 1/22/2025, she and the aide discovered the bag was hanging on the railing and the ends of the bag were cut. Staff D denied removing the device or having any knowledge as to how the device was removed. Staff D did not notify the on-call staff. The facility policy regarding notification included: The Administrator and Director of Nursing must be notified of any of the following ASAP: There is only a 2-hour window to submit a report to the state. Do not delay on notifying reportable events. Reportable Events: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When abuse and/or neglect of any kind is suspected, including resident to resident. Elopement occurs. Police need to be notified within 10 minutes of resident noted missing Narcotic count is off A resident reports valuables missing Any unscheduled removal of External Devices (Catheters, Drains, Drainage bags, IVs, or other catheter devices). Please call the provider on call & hospice provider first, then call the DON/Administrator when: A resident has a fall with injury. A resident is sent to the ED (Emergency Department). Significant change in resident condition. A resident passes away. Non-Emergency: after you call the provider and contact family, please send a text to the DON/Administrator when: A resident has a fever, vomits, loose stools, or signs and symptoms of infections. Witnessed/unwitnessed falls without injury. (If unwitnessed, start neurological checks immediately, open a risk management, and put an intervention in place). The Change of Condition Policy dated 3/26/2021 included:Purpose: To ensure that appropriate care and documentation occurs when residents experience a change of condition. Procedure: 1. Assess the resident's condition: limited movement, neurological checks for injuries such as falls, pain, swelling, bruising, discoloration, fever or vital signs outside defined parameters, etc. 2. Notify the attending physician promptly. 3. Notify the family. 4. Document symptoms, assessment, treatment, notifications, etc. 5. Follow up nursing assessments and monitoring until the condition has stabilized for at least 24 hours. Assess signs and symptoms and factors related to change in condition every 4 hours, more often if symptomatic. Resident Notification Education on 1/22/2025 included: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per facility policy Administrator, DON, and On-Call provider must be notified immediately for any unscheduled removal of external devices, (catheters, drains, drainage bags, IV's or other catheter devices). This is to ensure that delay in cares are prevented and resident safety is maintained. Call the healthcare provider right away if you have any of these: for any patient with a Cholecystostomy the following warrants immediate notification: jaundice, fever, chills, redness or swelling of the incision, incision pain, dark or [NAME] colored urine, stool that is light in color, increasing belly pain, rectal bleeding, trouble breathing or shortness of breath and leg swelling.