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	06/13/2024

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 42133 Based on clinical record review, document review, and staff interview, the facility failed to provide the Advanced Beneficiary Notice of Non-coverage (SNF ABN) to the resident or their legal representative within 48 hours of the ending of Medicare Skilled Part A therapy services for 1 of 2 residents sampled (Resident #69). The facility reported a census of 15 residents. Findings include: The Electronic Census Record showed Resident #69 admitted to Medicare Part A Skilled services on 2/23/24 and discharged from services on 3/14/24 remaining in the nursing facility. A 3/12/2024, 12:30 Communication with the Therapy Department Late Entry Progress Note documented Physical Therapy (PT) reported the resident was not progressing and would discharge from PT, Occupational Therapy (OT), and Speech Therapy (ST) on Thursday 3/14/24. The Power of Attorney was notified via phone and a discussion took place in the resident's room at 2 PM when the legal representative was present. Resident #69 wanted to return to independent living. Therapy recommended 24/7 caregiver, assistance of one staff with a forward wheeled walker and a gait belt. The family did not feel the resident was safe to return back to independent living and wanted Resident #69 to stay in the facility. The Progress Notes further documented on 3/15/24 the resident remained in the facility and the family would be setting up a consult with hospice care. On 6/10/24 the Administrator provided a Survey Readiness Binder which contained a Beneficiary Notice Entrance Conference Worksheet which documented Resident #69 discharged from Medicare Skilled services on 3/14/24 and remained in the nursing facility private pay. The Survey Readiness Binder also contained two Detailed Explanation Notices of Non-coverage for Resident #69 for the ending of ST services on 3/13/24 and the ending of PT and OT on 3/14/24. The Survey Binder lacked documentation the resident or the legal representative had been provided the SNF ABN notice prior to the ending of Medicare Skilled services on 3/14/24. (continued on next page)

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

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	06/13/2024

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 6/12/24 at 10:33 AM the Director of Nursing (DON) explained she is responsible for serving the beneficiary notices. She reviewed the Detailed Explanation of Non-coverage Form for Resident #69 and questioned if she served the wrong form. The DON voiced there was discussion with the family if Resident #69 would discharge home or stay in the facility, but she ended up staying in the facility. The Resident and Legal Representative did not appeal the decision to go off of Medicare services. She reported she did not have the SNF ABN form and was not familiar with the form. She voiced she had trained with the Administrator and the nurse consulting agency on serving the beneficiary notices. The SNF ABN had not been provided to the resident or the legal representative.

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	06/13/2024

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 42134 Based on clinical record review, Long Term Care Facility Resident Assessment Instrument (RAI) review, and staff interview, the facility failed to complete a significant change Minimum Data Set (MDS) within 14 days of determining a significant change for 2 of 2 residents reviewed for significant change (Residents #4 and #15). The facility reported a census of 15 residents. Findings include: The Physician Orders for Resident #4 included an order dated 12/4/23 to admit to hospice. Resident #4's Progress Note written on 12/4/23 at 12:06 PM documented the resident was being admitted to hospice. The clinical record lacked documentation of a decline or condition change prior to this date. The Significant Change Minimum Data Set (MDS) for Resident #4 documented an Assessment Reference date (ARD) of 12/11/23. The MDS was signed off as complete on 12/25/23 (21 days after the noted need for hospice services). Resident #15's Progress Note written on 2/23/24 at 8:49 AM documented an order from the Primary Care Provider (PCP) for a hospice consult and may admit. The Significant Change MDS for Resident #15 documented an ARD of 3/7/24. The MDS was signed off as complete on 3/12/24 (18 days after the noted need for hospice services). The RAI 3.0, version 1.17.1 dated October 2019, directs the significant change MDS be completed no later than the 14th calendar day after determining a significant change in resident status has occurred. The RAI includes hospice services as a significant change. During an interview on 6/11/24 at 3:25 PM, the MDS nurse explained she works remotely for a consulting company and is only onsite approximately every 3 months. She does all record review and MDS completion remotely. She further explained she does not have any policies for completing the MDS, she follows the RAI manual guidelines. During an interview on 6/12/24 at 8:20 AM the Director of Nursing (DON) explained the facility does not have a policy for MDS completion, they follow the RAI manual guidelines.

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	06/13/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on clinical record review, policy review, and staff interview, the facility failed to document the implementation of non-pharmacological interventions (any type of health care intervention which is not primarily based on medication. Some examples include toileting, exercise, diversion activity, snacks, naps, music, etcetera) prior to medication administration for 1 of 2 residents sampled for as needed anti-anxiety medication (psychoactive medications are substances that, when taken in or administered into one's system, affect mental processes, e.g. perception, consciousness, cognition or mood and emotions) (Resident #10). The facility identified a census of 15 residents. Findings include: Resident #10 Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS listed diagnoses of unspecified dementia and depression, and noted the use of antidepressant medication. A Order Summary Report signed by the Provider on 3/29/24 documented an order for Lorazepam (psychoactive medication) oral tablet 0.5 milligrams (MG). Give 1 tablet by mouth every 2 hours as needed for anxiety/restlessness. Start date 10/04/23. The Care Plan revised 4/26/24 lacked direction to the staff on interventions to try prior to administration of the as needed Lorazepam medication. A 6/12/24 review of the May and June 2024 Medication Administration Records and Progress Notes revealed the Lorazepam 0.5 mg as needed medication was administered without documentation of non-pharmacological interventions being trialed at the following times: a. 5/26/24 at 0:32 AM, 8:39 AM, 5:59 PM, and 10:00 PM b. 6/09/24 at 8:10 AM c. 6/08/24 at 4:00 PM and 10:40 PM A 6/12/24 review of the May and June 2024 Behavioral Progress Notes documented the following entries: a. 5/26/24 no Behavioral Progress Note documentation. b. 6/08/24 1:42 PM Behavior Note documented Resident #10 being rude to the nurse regarding her medication. No other entries for behaviors or interventions were recorded for 6/08/24. (continued on next page)

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	06/13/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. 6/9/2024 10:44 Behavior Note this morning the resident would press her doorbell and when staff would go into her room the resident would be snoring. When this nurse went in and asked her what she needed, the resident was rude and demanded her medication. The nurse explained she needed to sit up in bed or get up for breakfast first as she was lying flat on her back. The resident continued to demand the medication. The nurse explained again no medication would be administered while lying flat on her back for safety reasons. Resident agreed to raise the head of her bed. The medications were administered. The nurse asked if there was anything else she needed. The resident said no, nurse left room. The resident rang her doorbell before nurse made it to nurse's station. The nurse went back in; resident demanded the nurse to pick up her TV remote off the floor. The resident's rude and demanding behaviors are worse than before she became ill with a respiratory illness. The resident's husband stated yesterday, if she's being mean, just let her be mean. The 6/09/24 entry lacked documentation of the nurse offering interventions to try to decrease the resident's anxiety. A 6/12/24 review of the May and June 2024 Task Record revealed Certified Nursing (CNA) Staff documenting initial in a box for Behavior Monitoring and Intervention each shift. The entries lacked documentation of actual non-pharmacological interventions or specific behaviors noted during the shifts. The May and June 2024 Task Records for Behavior Symptoms documented none of the above or response not required for behavior documentation. On 6/12/24 at 7:44 AM Staff C, CNA reported they document resident behaviors in Point Of Care (POC, electronic health record). They notify the nurse of any behaviors that are not resolving with interventions like snack, activity, ambulation, toileting, music, 1:1 which are some of the interventions they use. The nurses document the behaviors and interventions. On 6/12/24 at 8:12 AM Staff A, Registered Nurse (RN) reported the CNAs try interventions when behaviors are noted. They document behaviors in POC. She is not sure about target behaviors, but the unit only has 15-16 residents so the staff know the residents behaviors and interventions pretty well. She reported she documents behaviors and interventions in the Progress Notes. She verbalized as needed medications should be the last resort, so interventions should be documented by the time an as needed medication is used. It is the last measure. During an interview on 6/12/24 at 10:05 AM the Director of Nursing (DON) explained she expected the nurse to document the behavior the resident exhibited and then the interventions the nurse provided that failed prior to giving an as needed (psychoactive) medication. The nurses would document that information in the behavior progress notes. During an interview on 6/13/24 at 8:54 AM Staff D, Licensed Practical Nurse (LPN) reported if she would administer an as needed antianxiety medication, she would document the resident behavior and interventions tried in the nursing progress notes or in the behavior progress notes. Interventions would include things like offering toileting, a snack, repositioning, or a diversional activity. The Psychoactive Drugs in Nursing Facility Policy, reviewed by the facility 6/12/24, documented a purpose to ensure the safe and appropriate use of psychoactive drugs in a nursing facility. The Policy noted the Quality Assurance and Process Improvement Program should monitor outcomes of the interventions implemented. The Policy lacked direction to the nursing staff on implementation and documentation of non-pharmacological interventions with the use of as needed psychoactive medications.

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	06/13/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on clinical record review, observation, document review, and staff interview, the facility failed to utilize a clean barrier under a blood glucose meter and failed to sanitize the blood glucose meter according to the facility policy/manufacturer's directions for 2 of 2 residents observed (Resident #6 and #9). The facility reported a census of 15 residents. Findings include: 1. Resident #6 Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented Resident #6 utilized insulin medication for a diagnosis of diabetes mellitus. A Physician Order Summary Report signed by the Provider on 6/7/24 listed an order to check the blood sugar twice a day at alternating times, two times a day on odd days. Resident #6 Care Plan revised 4/26/24 documented a Focus Problem of a diagnosis of diabetes mellitus type two and received insulin and oral hypoglycemic medications. The Care Plan intervention directed the staff to provide blood glucose checks as (physician) ordered. During an observation on 6/11/24 at 7:33 AM Staff A entered Resident #6 room and placed the blood glucose meter directly on the bedside table without a clean barrier. An emesis basin with a tube of toothpaste and a toothbrush sat approximately five inches from where the blood glucose meter, cotton ball, alcohol prep pad and bottle of test strips had been sat directly on the bedside table. Staff A washed her hands, donned gloves and brought another pair of gloves and sat the gloves under the blood glucose meter. Staff A completed the blood sugar, then stored Resident #6 meter without cleaning the meter. Staff A failed to sanitize the blood glucose meter according to the manufacturer's recommendations. During an interview on 6/11/24 at 8:48 AM Staff A, RN, confirmed she had not cleaned Resident #6 blood glucose meter after use. She reported she thought the night shift cleaned the blood glucometer when they did the control checks. Staff A reviewed the Glucose Control Testing Log and reported she didn't see any area where it specified they were cleaning the blood glucose meters, but she thought that is when they did it. 2. Resident #9 MDS assessment dated [DATE] showed a BIMS score of 14 indicating intact cognition. The MDS documented Resident #9 with a diagnosis of diabetes mellitus type two with diabetic neuropathy. An Order Summary Report signed by the Provider on 5/03/24 documented a physician order to check the blood sugar at alternating times two times a day. The June 2024 Medication Administration Record (MAR) showed Resident #9 due for the blood sugar check on 6/12/24 in the morning (AM). (continued on next page)

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	06/13/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/12/24 at 8:01 AM Staff A checked Resident #9 MAR, opened the medication cart and retrieved supplies to check the Resident's blood sugar. Staff A entered Resident #9's room, placed the bottle of test strips, alcohol prep pads and cotton ball directly on the bedside table and placed the blood glucose meter half on top of a disposable glove and half on the bedside table. Resident #9 bedside table had a clothes pin [NAME], several bags of snacks, a cloth napkin, and a brochure laying on the bedside table. The area where Staff A laid the meter and supplies had a white colored dried half ring on the table. Staff A washed her hands, donned gloves, came back to the bedside table, cleansed the front screen on the meter with an alcohol prep pad, then placed the meter back on top of the bedside table without a clean barrier, slide the meter around on the table to put a testing strip in the meter, and continued to perform the blood sugar. At 8:08 AM Staff A placed the meter on top of the medication cart without a clean barrier. Staff A picked the meter up, cleansed the meter with an alcohol prep pad for a few seconds, then placed the meter back down in the same spot on the top of the medication cart before finally storing in the medication cart. During an interview on 6/12/24 at 8:12 AM Staff A explained she had not received any retraining since the last blood sugar she performed for the Surveyor and she had not received any training on the facility policy on how to perform a blood sugar check or how to clean the blood glucose meter. She verbalized she did not know what the facility policy required for the use of a clean barrier or the cleaning. She reported she would have to check the facility policy, but it is basic nursing that a clean barrier should be used and the meter should be cleaned after use. Staff A voiced she was not aware of the manufacturer's recommendations for cleaning the meter. During an interview on 6/12/24 at 10:14 AM the Director of Nursing (DON) voiced she expects the nurses to use a paper towel under the equipment that goes in the resident's room. After the procedure, she would dispose of the barrier, then take a PDI wipe (germicidal agent) and wipe the meter down and let the meter sit for 2 minutes before storing in the medication cart. She voiced she was not aware of the manufacturer's recommendations and reported she would have to look at the facility policy. During an interview on 6/12/24 at 1:48 PM the DON reported she was not aware of the Microdot Xtra Blood Glucose Monitoring System Operation & Quality Assurance Procedure Manual. She voiced she didn't know how old the manual was that came with the meters and she would have to update their information. The Blood Sugar Monitoring Policy reviewed 6/12/24 directed the following procedure would be used for disinfecting accu check (blood sugar) machines after each use: a. When using the accu check machine in a resident's room, place a barrier (such as a paper towel) between the machine and the surface (such as a bedside stand). b. After use, wrap the meter in a antibacterial wipe and let set for the wet time designated per the manufacturer's guidelines. The Super Sani Cloth General Guidelines for use provided by the DON on 6/12/24 documented the germicidal disposable cloth needed to remain wet on the surface for 2 minutes and allowed to air dry. The Infection Control Program Policy dated 3/24/21 directed items and equipment will be sanitized and cleaned per the manufacturer's instructions. The glucometers will be sanitized utilizing the appropriate product following their directions. (continued on next page)

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	06/13/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Micro Dot Xtra Operations & Quality Assurance Procedure Manual specified the following cleaning procedure: Always use personal protective equipment as specified on the Microdot(R) Bleach Wipe label. Thoroughly clean gross filth and heavy soil from surface of Microdot(R) Xtra Glucometer to be disinfected. 1. Open Microdot(R) Bleach Wipe pop-up canister. The wipes are pre-saturated with a sodium hypochlorite (bleach) hospital-use solution. 2. Remove a pre-saturated 6 x 6 wipe. 3. Thoroughly wipe the Microdot(R) Xtra Glucometer surface to be disinfected. 4. Wrap the glucometer with the Microdot(R) Bleach 5. Place the wrapped Microdot(R) Xtra Glucometer face down inside the Microdot(R) Disinfection Case. 6. Close disinfection case lid and activate 3 minute timer. 7. Allow the Microdot(R) Xtra Glucometer to remain in contact with the bleach wipe for 3 minutes. 8. Dispose of wipe in trash after use. Do not flush wipe in the toilet. 9. Dispose of the non-refillable empty canister according to state and local authorities guidelines as allowed by the Microdot(R) Bleach Wipe label.