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	04/24/2025

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on clinical record review, Center for Medicare and Medicaid Services (CMS) Long-Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) Assessment for 1 of 2 residents reviewed for falls with major injury (Resident #7). The facility reported a census of 15 residents. Findings include: Resident #7 MDS assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 9 out of 15 indicating a moderate cognitive loss. The MDS documented Resident #7 with a bilateral lower body (hips, knees, ankle, foot) functional impairment and required the use of a walker and wheelchair for mobility. Resident #7 required supervision to touch assistance for sit to stand transfers from bed/chair and partial/moderate assistance to walk 10 feet or less. The MDS listed active diagnoses of type two diabetes mellitus with neuropathy (nerve damage), anemia, arthritis, thyroid disorder, and Non-Alzheimer's Dementia. The MDS further documented Resident #7 had two falls with major injuries (bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma (a life-threatening condition where blood accumulates between the brain and its outer covering) since the prior MDS assessment completed on 10/21/24. A 4/21/25 review of Resident #7 Unwitnessed Fall Reports dated 4/02/25, 3/05/25, 2/28/25, 2/18/25, 1/1/25, 12/28/25, and 11/23/25 all documented Resident #7 with no injuries from the unwitnessed falls. A 4/21/25 review of the Electronic Healthcare Record (EHR) Progress Notes from 10/21/24 to 1/06/25 lacked documentation of any major injuries from falls occurring in the facility, hospital, or outside in the community. During an interview on 4/21/25 at 2:47 PM the Director of Nursing (DON) reported he had checked back and the resident had not had any major injuries from falls that he could find. He reported he could check further into the prior DON's documentation but could not see where any residents had had any falls with major injury. On 4/23/25 at 10:20 AM Staff A, Licensed Practical Nurse (LPN) voiced to her knowledge Resident #7 had not sustained any major injuries from any falls in the past few months. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 4/23/25 at 11:00 AM the DON reported he does not recall Resident #7 having any major injuries from any falls since the prior MDS Assessment (10/21/24). He reviewed the definition of Major Injury from the RAI manual and voiced he did not feel they were using the correct definition of major injury and the MDS was inaccurately coded. On 4/23/25 at 12:45 PM the DON reported they follow the RAI for coding the MDS. He has utilized a MDS consultant that reviews MDS assessments as well. The LTC RAI 3.0 User's Manual, Version 1.19.1, October 2024 on Page 1-4 directs the RAI process has multiple regulatory requirements. Federal regulations at 42 Code of Federal Regulations (CFR) 483.20 (b)(1)(xviii), (g), and (h) require that the assessment accurately reflects the resident's status. The MDS RAI 3. 0 Manual Page J-37 under Number of Falls Since Prior Assessment, Steps to Assessment directs if this is not the first assessment, the review period is from the day after the Assessment Reference Date (ARD) of the last MDS assessment to the ARD of the current assessment and to review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41537 Based on observation, record review, staff interviews, and policy review the facility failed to ensure 1 of 3 residents at risk for elopement from the facility remained in the facility (Resident #9). The facility reported a census of 15 residents. Findings include: The Minimum Data Set (MDS) for Resident #9 dated 2/10/25 documented a Brief Interview of Mental Status (BIMS) of 9 indicating moderate cognitive impairment. The MDS revealed she is independent without staff assistance for dressing, bed mobility, transferring, and walking. The MDS also documented diagnoses of Wernicke's encephalopathy, cognitive communication deficit, and hypertension. Record review of the facilities undated, Final Report for Resident #9 elopement on 04/08/2025 documented the following timeline of events that occurred: a. At 2:15 PM Resident #9 was last seen by staff visiting another resident on the unit b. At 2:38 PM Staff B, [NAME] was driving by the facility and observed Resident #9 outside next to the facilities local church, Resident #9 walking down the sidewalk. Staff B immediately turned her vehicle around and stayed with Resident #9 and notified facility staff by phone. c. At 2:46 PM Resident #9 was back in the facility, the Director of Nursing (DON) completed an assessment and no injuries were found. Resident #9 was cooperative and stated that someone held the door open for her. Immediate response after resident's return on 04/08/2025: a. Head to toe assessment completed and revealed no injuries. Updated Wandering Risk Scale completed. b. Notified Resident #9 Doctor and family contact of incident. c. 15 minute checks initiated for resident safety and will remain in place until door code can be changed. d. The Administrator contacted a local security company to change door code and time it takes for alarm to sound. d. The Interdisciplinary team completed investigation and witness statements regarding response to elopement, it was determined that staff acted according to policy with no issues found. f. The interdisciplinary team reviewed elopement policy, and finds no changes necessary. A review of the policy by all staff members is initiated as a reminder of how to respond to elopements. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continuation on 04/09/2025: a. Care plan reviewed & updated with history of elopement b. Local security company completed door code change and decreased the time the alarm takes to go off from 10 seconds to 7 seconds. Record Review of Resident #9 Progress Notes on 4/21/25 revealed she had no behaviors or prior incidents of exit seeking and trying to leave the locked unit. Record Review of Resident #9 Care Plan on 4/21/25 revealed she had no behaviors or prior incidents of exit seeking and trying to leave the locked unit. During an interview with the states Climatologist (a scientist who studies the Earth's climate) on 4/21/25 at 2:59 PM informed on 4/8/25 in the city of Strawberry Point, Iowa it was 48 degrees, humidity 22%, 7 mile per hours MPH winds that made it feel like 45 degrees outside with the wind-chill, sunny and no precipitation. During an interview and observation on 4/22/25 at 3:19 PM with the Administrator revealed the facility checks the doors daily and has not had any issues with alarms not working prior or after elopement incident with Resident #9 on 4/8/25 she revealed she believes Resident #9 followed an employee out of the unit as the alarm had a 10 second delay. She revealed the door alarm never sounded around the time Resident #9 eloped from the facility, and if she had to guess she thinks maybe Resident #9 followed an employee out of the locked unit but the employee didn't notice to be able to intervene and that is why they lowered the amount of time for the door to sound to seven seconds. She revealed Resident #9 had no exit seeking behaviors leading up to this elopement and was acting her normal self. She revealed the system and policy were followed. After completion of the interview the Administrator showed the route the facility believes Resident #9 took, out the main entrance onto sidewalk and up to the parking lot. She informed Resident #9 is not a fall risk and has a very good gait. She informed Resident #9 was wearing a sweatshirt, pants and tennis shoes. After the facility assisted her back in she informed she was fine and told staff how nice of a day it was outside. Record review of the facilities Resident Elopement policy revised 2/7/25 revealed the facility followed protocol for the elopement of Resident #9 on 4/8/25. Facility staff implemented immediate interventions on 4/8/25 and completed on 4/14/25 through the following actions: a. Head to toe assessment and wandering assessment completed and revealed no injuries or changes to her baseline status. b. Doctor and family notification completed. c. Implemented 15 minute checks for resident safety and will remain in place until door code can be changed. d. Interdisciplinary team completed investigation and witness statements regarding response to elopement, it was determined that staff acted according to policy with no issues found. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. The interdisciplinary team reviewed elopement policy, and finds no changes necessary. A review of the policy by all staff members is initiated as a reminder of how to respond to elopements. f. On 4/9/25 door code was changed and time for alarm to be set off was decreased by 7 seconds. The deficient practice was identified as past non-compliance singular event as of 4/14/25, the elopement occurred prior to the survey, after the facility completed review for the current residents at risk and education was completed for all staff.