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	06/17/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, guardian interview, and staff interview the facility failed to ensure a resident's legally appointed guardian received timely notification regarding medication changes and equipment management issues regarding hearing aids for 1 of 3 residents reviewed (Resident #17). The facility reported a census of 15 residents. Findings include: The Minimum Data Set, dated [DATE] documented that Resident #17 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. The assessment noted Resident #17 had moderate difficulty with hearing, and used a hearing aid or other hearing appliance. Active diagnoses per the MDS included heart failure (weak heart muscle), non-Alzheimer's dementia, and chronic pain.A Progress Note titled Communication dated 6/15/26 at 11:02 AM revealed Resident #17's hearing aids were dropped off at the post office for repair and lacked notification to his legal representative. A Progress Note titled Order Note dated 6/15/26 at 12:15 PM instructed an order for a Fentanyl patch 12 mcg/hr (micrograms per hour) to change every 72 hours. This medication order lacked notification to his legal representative. On 6/16/26 at 8:14 AM Resident #17's Guardian stated during an interview that the facility didn't keep her updated on changes since Resident #17's admission to the facility. She noted she didn't know about the use of a Fentanyl patch or that the hearing aids left the facility for repairs. An interview on 6/17/26 at 12:05 PM with the Director of Nursing (DON) revealed facility staff use a secure email system to notify Resident #17's representative or will call her directly to notify of changes. She revealed she did not think his guardian was updated regarding the hearing aids, but should have been.

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of electronic health records (EHR), the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025, and staff interviews, the facility failed to complete and submit Minimum Data Set (MDS) assessments as required for 2 of 2 sampled residents (Resident #15 and Resident #3). The facility reported a census of 15 residents.Findings Include:1. Review of the facility Census List on 6/16/26 for Resident #15 revealed he was admitted to the facility on [DATE] and passed away on 3/17/26. Resident #15's Minimum Data Set (MDS) log in the Electronic Health Record (EHR) reviewed on 6/16/26 lacked a Death in Facility Tracking MDS. The review revealed the facility staff had not started or completed this tracking record. On 6/17/26 at 11:36 AM, an interview with the MDS Coordinator revealed she missed the discharge tracking record for Resident #15. She noted she should've completed a discharge MDS assessment for 3/17/26 and planned to create it immediately. She acknowledged Resident #15 required a discharge MDS within 14 days and should have been submitted within 28 days, meaning the tracking records would transmit late. She stated she followed the Resident Assessment Instrument (RAI) User's Manual and followed up with the facility if needed. On 7/17/26 at 12:05 PM, an interview with the Director of Nursing (DON) revealed she expected staff to complete and submit all MDS records on time. She stated the MDS Coordinator must follow the RAI manual and facility policies. 2. Review of the EHR for Resident #3 revealed the MDS dated [DATE] had a completed date of 5/15/26. The MDS showed an acceptance date of 6/3/26. During an interview on 6/17/26 at 11:32 AM, the Interim MDS Coordinator stated that she had been responsible for completing MDS assessments. The MDS Coordinator acknowledged awareness of the RAI Manual and understood the submission deadline to be 14 days after completion of an MDS. Regarding Resident #3's Quarterly MDS (Assessment Reference Date 05/14/2026), the MDS Coordinator confirmed that it was completed on 05/15/2026, but not submitted until 06/03/2026, missing the required deadline of 05/29/2026. During an interview on 6/17/26 at 12:03 PM, the Director of Nursing confirmed her expectation that MDS assessments be completed and submitted timely. Regarding Resident #3, the DON acknowledged the quarterly assessment was submitted late. In an email correspondence with the Administrator on 6/17/26 at 12:07 PM, the Administrator revealed the facility used the MDS RAI Manual, not any company policy, for the completion of the MDS's. According to the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.20.1), facilities must adhere to the following regulatory timelines regarding the MDS. Completion: For non-admission OBRA and PPS assessments, the MDS Completion Date (Z0500B) must occur within 14 days of the Assessment Reference Date (ARD) (A2300). (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encoding: Data must be entered into the facility's software within 7 days of the MDS Completion Date (Z0500B + 7 days) for Quarterly, Significant Correction to Prior Quarterly, Discharge, or PPS assessments. Transmission: Non-comprehensive MDS assessments must be electronically submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code a Minimum Data Set (MDS) assessment to reflect Preadmission Screening and Resident Review (PASRR) status for 1 of 3 residents reviewed (Resident #16). The facility reported a census of 15 residents. Findings include: The MDS dated [DATE] for Resident #16 documented the resident was not considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #16's current PASRR document dated October 2023 documented a notice of a PASRR Level II Outcome. The PASRR Determination was approved with specialized services.Review of Resident #16's current Care Plan on 6/16/26 documented PASRR goals and interventions.On 6/17/26 at 11:36 AM, the MDS Coordinator revealed during an interview that Resident #16 maintained a PASRR Level II status. The MDS Coordinator stated that she coded Resident #16's MDS inaccurately, as the assessment should show his Level II status. The MDS Coordinator noted that she'd submit a modification to correct the 2/27/26 MDS.On 7/17/26 at 12:05 PM, the Director of Nursing (DON) stated during an interview that the MDS Coordinator must follow the Resident Assessment Instrument (RAI) manual and facility policies.