| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165492 | A. Building<br>B. Wing | 05/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lakeside Lutheran Home | 301 North Lawler Street<br>Emmetsburg, IA 50536 |

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 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527<br><br>Based record review and staff interview, the facility failed to ensure residents were allowed to choose schedules, clothing, or bathing preferences for 2 of 4 residents reviewed (Resident #1 and #4). The facility reported a census of 34 residents.<br><br>Findings include:<br><br>1.) According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.The resident required substantial to maximal assistance with a shower/bath. The resident's diagnoses included anxiety and depression.<br><br>The Care Plan identified the resident had an activity of daily living self care performance deficit. The interventions included she required one staff assistance for completion of bathing.<br><br>The Progress Notes dated 4/26/25 at 9:10 a.m. documented Resident #1 accused the bath-aide Staff A Certified Nursing Assistant (CNA) of being rough and rushing her during shower and making her wait on her jewelry, commenting she didn't have time to pamper her right then.<br><br>An undated note titled Staff B Certified Medication Aide (CMA)'s Statement documented the resident said Staff A refused to use the jets (in the whirlpool) and would not pamper her the same as everyone else.<br><br>A note titled Resident #1's Statement with the Administrator and Director of Nursing (DON) included the resident said when Staff A put her in the bath she didn't turn the bubbles on and she said she didn't have time for them.<br><br>A note titled Staff A's Statement included the resident said something about bubbles. Staff A told resident #1 she couldn't [NAME] around, she had other resident's baths to do.<br><br>On 5/19/25 at 1 p.m. Resident #1 stated Staff A was mean. She said Staff A wanted to do her bath last, but they told her it had to be done before breakfast. She took her to the bath and only filled it up to her knees and would not run the jets. Staff A said she didn't have time for that.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/20/25 at 12:24 p.m. Staff A stated that morning they kept bringing people to her for a bath, and pressing her to get them done. She was told she was not doing them fast enough. So she didn't turn on the jets so the baths wouldn't take so long.<br><br>2) According to the MDS assessment dated [DATE], Resident #4 scored 15 on the BIMS indicating no cognitive impairment. The resident required substantial to maximal assistance with upper/lower body dressing, and was dependent for transfer to bed. The resident's diagnoses included heart failure and morbid obesity.<br><br>The Comprehensive MDS assessment dated [DATE] documented it was somewhat important for Resident #4 to choose what he wanted to wear and choose his own bedtime.<br><br>The Care Plan dated 4/1/22 identified the resident had altered respiratory status related to obstructive sleep apnea and used a Continuous Positive Airway Pressure (CPAP) machine at night.<br><br>The Care Plan dated 2/20/24 identified the resident had a psychosocial wellbeing problem or potential related to illness/disease process and decline in health, but mentally aware. Interventions included allowing him time to answer questions and to verbalize feelings, perceptions, and fears, and encouraging participation from resident who depends on others to make own decisions. Explain all procedures, all changes, rules, and options.<br><br>The Care Plan revised 4/1/22 identified the resident had an ADL self care performance deficit related to limited physical mobility. Interventions included total mechanical lift with assist x 2 for all transfers.<br><br>A Disciplinary Action Report dated 9/16/24 documented on the weekends of 9/2/24 and 9/11/24 the specific work rule identified resident rights. Staff A made the resident go to bed at 8 p.m. and wear a gown after he asked not to. Staff A put the resident's CPAP on wrong and wouldn't listen to the resident.<br><br>A note Written by Staff B Certified Nursing Assistant (CMA) and attached, included the resident reported to her that Staff A made him go to bed at 8 p.m. Staff A told him he had to wear a hospital gown because he was passing a lot of gas and they couldn't have that and that was why he had to be put in bed. She also put his CPAP on wrong and he tried telling her. No, he didn't want to go to bed and he didn't wear a gown. But she wouldn't listen.<br><br>The report was signed by the Director of Nursing (DON) and Staff A.<br><br>On 5/20/25 at 12:24 p.m. Staff A stated she did not recall the write up.<br><br>On 5/22/25 at 11:45 p.m. the DON stated Staff A signed the write up with no rebuttal.<br><br>The facility undated Resident's [NAME] of Rights included self-determination. The resident had the right to and the facility must promote and facilitate resident self- determination through support of resident choice, including but not limited to:<br><br>The resident had the right to make choices about aspects of his or her life in the facility that were significant to the resident. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527<br><br>Based on record review and staff interview, the facility failed to notify the physician, and the resident's representative immediately of a resident's allegation of rough treatment for 1 resident (Resident #1). The facility reported a census of 34 residents.<br><br>Findings's include:<br><br>According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required substantial to maximal assistance with a shower/bath. The resident's diagnoses included anxiety and depression.<br><br>The Progress Notes dated 4/26/25 at 9:10 a.m. documented Resident #1 accused the bath-aide (Staff A Certified Nursing Assistant (CNA) of being rough and rushing her during shower (her breast got pinched with a gait belt, and jammed toothbrush in her mouth). The resident also complained of pain in her breast radiating to the back of her shoulder, feeling weak, and unable to walk. The resident assisted to her room via wheelchair. Vital Signs and Blood Sugar checked and within normal limits. No evidence of injury noted to left breast at this time. Would continue to monitor. The Director of Nursing (DON) notified of the incident.<br><br>An Incident Report dated 4/26/25 documented the resident stated Staff A was rough with her during her bath on Saturday. She pinched her breast while she had her in her shower chair with the shower chair belt, jammed her toothbrush into her mouth and wouldn't turn the jets on. The Physician notified on 4/28/25 at 11:53 a.m. the Administrator notified on 4/28/25 at 7:56 a.m. and the family notified on 4/28/25 at 12 p.m.<br><br>A fax dated 4/28/25 notified the physician of Resident #1's allegation.<br><br>On 5/21/25 at 4:20 p.m. the DON confirmed the physician and resident representative were notified 4/28/25. They should have been notified the day the resident reported it. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527<br><br>Based on record review and staff interview the facility failed to notify the Department of Inspections, Appeals, and Licensing (DIAL) of an allegation of potential abuse within the required time frame for 1 resident reviewed (Resident #1). The facility reported a census of 34 residents.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required substantial to maximal assistance with a shower/bath. The resident's diagnoses included anxiety and depression.<br><br>The Progress Notes dated 4/26/25 at 09:10 a.m. documented Resident #1 accused the bath-aide of being rough and rushing her during shower (she pinched her breast with the gait belt, and jammed the toothbrush in her mouth).<br><br>On 5/20/25 at 9:30 a.m. Staff B Certified Nursing Assistant (CMA) stated Resident #1 told her that Staff A Certified Nursing Assistant (CNA) was rough in the bath. Her boob got pinched when she applied the bath chair safety belt. Staff A refused to turn the jets on. She also jammed the toothbrush in her mouth.<br><br>On 5/19/25 at 3:20 p.m. the (DON) said Staff A was taken off of baths and moved to north hall away from Resident #1 on Saturday, worked Sunday, and was suspended on Monday.<br><br>On 5/22/25 at 11:45 a.m. the Administrator stated they reported to the state on 4/28/25, and confirmed they had not reported the incident to the state agency (DIAL) timely.<br><br>The facility undated Abuse Prevention, Identification, Investigation and Reporting Policy documented all allegations of resident neglect, exploitation, mistreatment, injuries of unknown origin and<br><br>misappropriation should be reported to the Iowa Department of Inspections and Appeals, not later than two<br><br>(2) hours after the allegation was made, if the events that caused the allegation result in serious bodily injury, or not later than twenty-four (24) hours if the events that caused the allegation involved neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation of resident property, but do not result in serious bodily injury. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527<br><br>Based on record review and staff interview the facility failed to immediately separate an alleged abuser from all potential victims. The facility reported a census of 34 residents.<br><br>Finding's include:<br><br>According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #1 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident's diagnoses included anxiety and depression.<br><br>The Progress Notes dated 4/26/25 at 09:10 a.m. documented Resident #1 accused the bath-aide of being rough and rushing her during shower (she pinched her breast with the gait belt, and jammed the toothbrush in her mouth).<br><br>On 5/20/25 at 9:30 a.m. Staff B Certified Nursing Assistant (CMA) stated Resident #1 told her that Staff A Certified Nursing Assistant (CNA) was rough in the bath. Her boob got pinched when she applied the bath chair safety belt. Staff A refused to turn the jets on. She also jammed the toothbrush in her mouth. Staff B went to the charge nurse, who was from a temp agency. Together they called the Director of Nursing (DON). They made Staff A work away from the resident.<br><br>On 5/19/25 at 3:20 p.m. the DON said Staff A was taken off of baths and moved to north hall away from Resident #1 on Saturday, worked Sunday, and was suspended on Monday.<br><br>The facility undated Abuse Prevention, Identification, Investigation and Reporting Policy documented upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment, the facility should immediately implement measures to prevent further potential abuse of residents from occurring while the investigation was in process. If this involved an allegation of abuse by an employee, this would be accomplished by separating the employee accused of abuse from all residents. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527<br><br>Based on record review and staff interview the facility failed to ensure appropriate transfer techniques to prevent injury for 1 of 3 resident's reviewed (Resident #6). The facility reported a census of 34 residents.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #6 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment.The resident required partial to moderate assistance with sitting to standing. The resident's diagnoses included cancer, anemia, atrial fibrillation, and heart failure.<br><br>The Care Plan dated 7/24/24 identified the resident had an activity of daily living self care performance deficit related to weakness and cancer. The interventions included the resident had chronic pain at varied levels, and having 2 staff present with cares and mobility, may help with gentle moving and tasks to alleviate pain.<br><br>The Progress Notes dated 10/7/24 at 11:06 a.m. documented Resident #6 had skin tears to his right forearm<br><br>The surrounding skin was warm and dry, and blood noted from each skin tear. The areas measured:<br><br>a. 4 cm by 1cm,<br><br>b. 2.5 cm by 1 cm,<br><br>c. 2 cm by 1 cm.<br><br>Op-site (clear dressing) applied to each area. Education provided to staff on not grabbing the resident's arms because he had fragile skin.<br><br>A Disciplinary Action Report dated 10/7/24 documented Staff A Certified Nursing Assistant (CNA) violated a specific work rule by grabbing Resident #6's wrist instead of the gaitbelt, resulting in skin tears to his right forearm. Staff A signed the report.<br><br>On 5/22/25 at 11:55 a.m. the Director of Nursing (DON) stated Staff A signed the disciplinary action with no rebuttal. |