| 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 | 01/23/2025 |

| 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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875<br><br>Based on clinical record review, staff interviews and policy review, the facility facility failed to protect a resident from verbal and physical abuse by a staff member for 1 of 12 residents reviewed for abuse (Resident #24). The facility reported a census of 39 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) assessment for Resident #24 dated 12/10/24 identified a Brief Interview for Mental Status (BIMS) score of 03, indicating severely impaired cognition. The MDS identified Resident #24 was dependent on staff for bed mobility, toileting and transfers. The MDS documented Resident #24 had physical and verbal behavioral symptoms directed toward others 1 to 3 days per week. The MDS included diagnoses of hypertension (high blood pressure), pneumonia, diabetes mellitus, Alzheimer's disease, cerebrovascular accident with hemiplegia (stroke affecting one side), non-Alzheimer's dementia, anxiety, depression and adjustment disorder with mixed disturbance of emotions and conduct.<br><br>The Care Plan with a revised date of 12/4/24 documented Resident #24 had behavior problems related to anxiety and revealed Resident #24 may yell or strike out at staff who provide care. The Care Plan directed the following interventions:<br><br>-Staff to approach and explain the care that was going to be provided. Staff to give Resident #24 choices as needed. If Resident #24 irritated or agitated, staff to attempt to learn why. Staff to address Resident #24 personal needs such as pain, hunger and temperature. Staff to offer diversional activities and topics such as travel, fishing, working as a mechanic and farmer. Staff to use firm kindness and not to argue with Resident #24.<br><br>-If reasonable, staff to discuss Resident #24 behavior and explain why the behavior was not appropriate and unacceptable.<br><br>- Staff to intervene as necessary to protect the rights and safety of others. Staff to approach and speak in a calm manner and divert attention. Staff to remove Resident #24 from the situation and take to alternate locations as needed.<br><br>(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 |
|---|---|---|

| 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 | 01/23/2025 |

| 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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/16/25 at 1:50 PM, Staff A, CNA (Certified Nursing Assistant) reported last week either on Thursday or Friday around 7 AM, Staff B, RN (Registered Nurse) had gone to Resident #24's room to check his blood sugar. Resident #24 attempted to bite Staff B and Staff A helped stop him by grabbing his hand and when she did, he pulled his head away from Staff B. Staff B stated, If you bite me I will knock all the teeth out of your mouth and raised her hand to strike him. Staff A responded Hey and Staff B put her hand down.<br><br>On 1/16/25 at 2:10 PM, Staff B, RN reported when she got angry she might say she wanted to hit something but had never said anything to a patient. Staff B stated she thought she should take up boxing to help her get rid of some frustrations. Staff B said she would never say she wanted to hit something in a patient's room, she stated she had said it at the desk. Staff B said she had been a nurse for [AGE] years and would never want to hit a patient.<br><br>An Incident Report titled Alleged Neglect dated 1/16/25 at 5:18 PM documented a state official reported to nursing that a nursing staff yelled and raised a hand at Resident #24. The immediate action was the staff member was suspended.<br><br>A hand written statement completed by Staff C, CMA (certified medication aide) dated 1/16/25 documented he was down South and heard Staff B, RN say to Resident #24 if you hit me, I ' m going to smack you back. Staff C documented the incident happened in front of the nurses station where Resident #24 was parked before the staff brought him down for meals.<br><br>A handwritten statement completed by Staff A, CNA dated 1/20/25 documented she was in Resident #24's room and Staff B, RN came into the room. Staff B grabbed Resident #24's finger and he went to put his mouth on Staff B's hand. Staff B raised her hand. Staff A documented she told Resident #24 to hold still and let Staff B get his blood. Staff B put down her hand and said if you bit me I will knock every tooth out of your mouth. Staff A documented later on Staff B was at the nurses station telling everyone there what she said to Resident #24 that morning, I will knock every tooth out of your mouth.<br><br>On 1/21/25 at 10:30 AM, Staff C, CMA reported the statement written on 1/16/25 was about a previous incident that had happened. Staff C reported he had heard Staff B say to Resident #24, if you hit me, I'm going to smack you back. He reported it happened when Staff B was trying to obtain Resident #24's blood sugar in front of the nurses station where Resident #24 sat before going down for meals. Staff C reported he did not say anything to anyone about what he had heard. He reported he did not think Staff B would actually hit someone. Staff C reported he did not think any other staff members were around or heard it. He said the aides were down the hallways. He reported Staff B claimed that she liked to joke around. Staff C stated he did not remember the exact date the incident happened but thought it was either on a weekend or a Friday as that was when he worked as a medication aide with Staff B. He reported Staff B does get frustrated at times. He said one time when the aides had reported a resident had fallen and Staff B was needed in the resident room, she said, God Damn and then slammed the medications down on the medication cart. Staff C also reported he had seen Staff B smack her fist down on the table when she got frustrated. He said Staff B does not like to work by herself and gets upset when there was not a second nurse.<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/21/25 at 12:45 PM, Staff A, CNA reported she had gone back, looked at the schedule and determined the incident occurred on Monday,1/6/25 as she was giving baths that day and Resident #24 was scheduled for the bath. She stated she took the bath chair into the room with her and was going to get him up. She stated Staff B, RN came into the room to get Resident #24 blood sugar. She stated Staff B leaned over Resident #24, grabbed his hand and he tried to bite her. Staff A reported Staff B told Resident #24, Don't you dare bite me, I am going to knock every tooth out of your mouth. She stated Staff B raised her right hand in the air like she was going to slap him but she did not. She stated Staff B did not explain what she was going to do prior to trying to get his blood sugar. Staff A reported she was able to get Resident #24 to calm down and he did let Staff B do the blood sugar. She stated Staff D, CNA heard noises coming from outside the room and she came in. Staff A reported she told Staff D what had happened. Staff A reported Staff B was at the nurses station later on repeating what she had said to Resident #24.<br><br>On 1/21/25 at 2:30 PM, Staff D, CNA reported on 1/6/25 she had heard some noise coming from Resident #24's room and she went into the room to see if they needed any help. She stated Resident #24 was having his normal behaviors which was hitting and yelling. She stated Staff A, CNA and Staff B, RN were in the room and were either trying to get Resident #24's blood sugar or give medications. Staff D stated she was not sure which one but she knew something with nursing was taking place as Staff B was in the room. She stated she left the room and later returned to help Staff A transfer Resident #24 into the shower chair. Staff D stated later around lunch time Staff A had told her that the way Staff B was talking to Resident #24 made her uncomfortable. Staff D said she told Staff A that if it made her uncomfortable that she needed to report it. Staff D reported Staff A did not tell her what it was that Staff B had said that made her uncomfortable. Staff D reported Staff B was not nice to the staff. She stated Staff B would talk about staff behind their backs.<br><br>The untitled, undated, unsigned investigation summary provided by the facility on 1/21/25 documented on 1/16/25 a state surveyor entered the building regarding a complaint against Staff B, RN towards Resident #24. The summary revealed Staff B was suspended pending investigation on 1/16/25 when the Director of Nursing (DON) was informed of the allegation.<br><br>On 1/22/25 at 7:20 AM, the Administrator reported she learned of the abuse allegations on 1/16/25. She stated she was out of the building and got a text that the nurse was being walked out and suspended. She stated the DON started the investigation on 1/16/25.<br><br>On 1/22/25 at 7:52 AM, the Administrator said she would expect staff to make sure the resident was safe and not in danger, report the allegations of abuse to the nurse or supervisor immediately, follow up/make sure the allegations were taken care of and if not tell someone else or report to the state themselves.<br><br>A facility policy titled ( facility name) Abuse Prevention, Reporting, Investigation Policy and Procedure revised April 2017 documented the residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. The administration and employees to take action to protect and prevent abuse and neglect from occurring within the facility by the following:<br><br>a. Not using verbal, mental, sexual and physical abuse, corporal punishment, or involuntary seclusion.<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b. Not employing individuals who have been found guilty of abusing, mistreating individuals by a court of law and have had a finding entered into the State Nurse Aide Registry concerning abuse, neglect, and/or mistreatment of residents or misappropriation of their property.<br><br>c. Reporting any knowledge of actions by a court of law against an employee for service as a Nurse Aide, or other nursing facility staff to the State Nurse Aide Registry of Licensing Authorities.<br><br>d. Ensuring that all alleged violations involving mistreatment, neglect, or abuse including, injuries, injuries of unknown source, and misappropriation of resident property are reported to officials in accordance with Federal and State laws and also to the Administrator, DON, and the Resident Services Director.<br><br>e. Providing evidence that all alleged violations are thoroughly investigated and thereby preventing further potential abuse while an investigation is in process.<br><br>f. Reporting results immediately to the State Survey Agency<br><br>g. Taking corrective action in cases where alleged abuse is verified. |

| 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 | 01/23/2025 |

| 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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>46875<br><br>Based on personnel record review, staff interviews and policy review the facility failed to provide appropriate screening prior to employment for 2 of 5 employees reviewed for background checks. The facility did not receive approval for the employee to work after the criminal background check revealed the employees had a past criminal history. The facility reported a census of 39 residents.<br><br>Findings include:<br><br>1. The personnel file for Staff E, (Certified Nursing Assistant) documented a start date of 7/29/24. The Single Contact License and Background Check (SING) dated 7/15/24 indicated a criminal history record was found and required further research. The Iowa Criminal History results revealed Staff E had been charged with operating while intoxicated, 1st offense. The personnel file for Staff E lacked documentation that a record check evaluation was conducted and an approval to work was obtained through the Iowa Department of Human Services.<br><br>Review of current nursing schedules revealed Staff E was an active CNA at the facility.<br><br>2. The personnel file for the active DON (Director of Nursing) documented a start date of 5/13/24. The Single Contact License and Background Check (SING) dated 5/3/24 indicated a criminal history record was found and required further research. The Iowa Criminal History results revealed the DON had been charged with operating while intoxicated, 1st offense. The personnel file for the DON lacked documentation that a record check evaluation was conducted and an approval to work was obtained through the Iowa Department of Human Services.<br><br>During the survey, the DON was actively working.<br><br>On 1/23/25 at 12:20 PM, the Administrator reported the facility did not have any documentation indicating the employees had been approved to work. She stated since it has been more than 30 days since the background checks had been completed the facility was not able to obtain any additional information from the Iowa Department of Human Services. The Business Office Manager (BOM) was present and reported after the facility received the criminal background check history, the facility did not do anything further. The Administrator acknowledged the facility abuse policy did not address screening of new employees or completing background checks. The Administrator reported she did not have any other policies or procedures that address completing background checks.<br><br>A facility policy title (facility name) Abuse Prevention, Reporting, Investigation Policy and Procedure revised April 2017 documented the residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. The administration and employees to take action to protect and prevent abuse and neglect from occurring within the facility by not employing individuals who have been found guilty of abusing, mistreating individuals by a court of law and have had a finding entered into the State Nurse Aide Registry concerning abuse, neglect, and/or mistreatment of residents or misappropriation of their property. The policy failed to include direction on screening of new employees and when/how to conduct background checks on new employees. |

| 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 | 01/23/2025 |

| 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 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** 46875<br><br>Based on staff interview, personnel record review, facility investigation review, and policy review the facility failed to notify DIAL (Department of Inspection, Appeals and Licensing) of an alleged verbal and physical abuse for Resident #24 that occurred on 1/6/25 at 7:00 AM in a timely manner. The CNA (Certified Nursing Assistant) reported she told the DON (Director of Nursing) of the allegations of abuse later that afternoon on 1/6/25. The DON denied being told or hearing of the allegation of abuse. The facility investigation for the alleged abuse was initiated on 1/16/25 after DIAL entered the facility and notified the DON of the allegations. The facility reported the incident to DIAL on 1/16/25 at 3:34 PM. The facility reported a census of 39 residents.<br><br>Findings include:<br><br>On 1/16/25 at 1:50 PM, Staff A, CNA reported last week either on Thursday or Friday around 7 AM, Staff B, RN (Registered Nurse) had gone to Resident #24's room to check his blood sugar. Resident #24 attempted to bite Staff B and Staff A helped stop him by grabbing his hand and when she did, he pulled his head away from Staff B. Staff B stated, If you bite me I will knock all the teeth out of your mouth and raised her hand to strike him. Staff A responded Hey and Staff B put her hand down. Staff A reported Staff D, CNA had come into Resident #24's room right after the incident because she had heard raised voices. Staff A reported she had told Staff D what had happened and Staff D told her that it was inappropriate and to tell the DON. Staff A reported it was a really busy day so she told the DON around 3 PM and the DON said she would deal with it. When asked if the DON had done anything, Staff A reported she never went back to follow up. Staff A reported she had worked the following weekend and Monday and Staff B had also worked the weekend. Staff A reported she had also told Staff E, another CNA about the incident.<br><br>On 1/16/25 at 2:10 PM, Staff B, RN reported when she got angry she might say she wanted to hit something but had never said anything to a patient. Staff B stated she thought she should take up boxing to help her get rid of some frustrations. Staff B said she would never say she wanted to hit something in a patient ' s room, she stated she had said it at the desk. Staff B said she had been a nurse for [AGE] years and would never want to hit a patient.<br><br>Review of the document titled Intake revealed the facility filed allegation of abuse with DIAL for Resident #24 on 1/16/25 at 3:34 PM.<br><br>An Incident Report titled Alleged Neglect dated 1/16/25 at 5:18 PM documented a state official reported to nursing that a nursing staff yelled and raised a hand at Resident #24. The immediate action was that a staff member was suspended.<br><br>A hand written statement completed by Staff C, CMA (Certified Medication Aide) dated 1/16/25 documented he was down South and heard Staff B, RN say to Resident #24 if you hit me, I ' m going to smack you back. Staff C documented the incident happened in front of the nurses station where Resident #24 was parked before the staff brought him down for meals.<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The untitled and unsigned facility investigation summary provided by the facility on 1/21/25 documented on 1/16/25 a state surveyor entered the building regarding a complaint against Staff B, RN towards Resident #24. It was reported Staff B was reported to have an allegation of abuse and it was reported to the DON and nothing was done. The summary documented the incident had not been reported to the Administrator at any time. The summary revealed Staff B was suspended pending investigation on 1/16/25 when the DON was informed of the allegation and an incident report was filed with DIAL.<br><br>A facility form titled Disciplinary Action Report dated 1/20/25 for Staff A, CNA documented the violation occurred on 1/6/25 as Staff A did not report alleged abuse immediately so it could be reported to DIAL. Staff A, CNA stated she watched Staff B raise her hand and yell at the resident. Staff A did not turn into supervisor immediately, which is policy, so the incident can be reported within 2 hours. The form was signed by the DON and Staff A on 1/20/25.<br><br>On 1/21/25 at 10:30 AM, Staff C, CMA reported the statement written on 1/16/25 was about a previous incident that had happened. Staff C reported he had heard Staff B say to Resident #24, if you hit me, I'm going to smack you back. He reported it happened when Staff B was trying to obtain Resident #24's blood sugar in front of the nurses station where Resident #24 sat before going down for meals. Staff C reported he did not say anything to anyone about what he had heard. He reported he did not think Staff B would actually hit someone. Staff C reported he did not think any other staff members were around or heard it. He said the aides were down the hallways. He reported Staff B claimed that she liked to joke around. Staff C stated he did not remember the exact date the incident happened but thought it was either on a weekend or a Friday as that was when he worked as a medication aide with Staff B. He reported Staff B does get frustrated at times. He said one time when the aides had reported a resident had fallen and Staff B was needed in the resident room, she said, God Damn and then slammed the medications down on the medication cart. Staff C also reported he had seen Staff B smack her fist down on the table when she got frustrated. He said Staff B does not like to work by herself and gets upset when there is not a second nurse.<br><br>On 1/21/25 at 11:31 AM, Staff E, CNA reported she had heard from Staff A, CNA that Staff A and Staff B, RN were getting Resident #24 up and Staff B said to Resident #24, I will knock out all of your damn teeth out of your mouth, if you try to bite me again. She said Staff A reported Staff B raised her right fist in the air. Staff A reported she thought it had happened on a Thursday and she heard about it the following day when she was working on 1/10/25. Staff E reported Staff A told her that she had reported the incident to the DON. Staff E reported Staff B had been mean before. When asked what she meant by mean, Staff E stated Staff B was not directly mean to the residents but would talk about them at the nurses station.<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/21/25 at 12:45 PM, Staff A, CNA reported she had gone back, looked at the schedule and determined the incident occurred on Monday,1/6/25 as she was giving baths that day and Resident #24 was scheduled for the bath. She stated she took the bath chair into the room with her and was going to get him up. She stated Staff B, RN came into the room to get Resident #24's blood sugar. She stated Staff B leaned over Resident #24, grabbed his hand and he tried to bite her. Staff A reported Staff B told Resident #24, Don't you dare bite me, I am going to knock every tooth out of your mouth. She stated Staff B raised her right hand in the air like she was going to slap him but she did not. She stated Staff B did not explain what she was going to do prior to trying to get his blood sugar. Staff A reported she was able to get Resident #24 to calm down and he did let Staff B do the blood sugar. She stated Staff D, CNA heard noises coming from outside the room and she came in. Staff A reported she told Staff D what had happened. Staff A reported Staff B was at the nurses station later on repeating what she had said to Resident #24. Staff A reported she could not recall who else was sitting at the nurses station. She stated later that week, she thought on Friday,1/10/25, Staff E, CNA asked her about the incident so she told Staff E what had happened. Staff A reported she had told the DON about the incident later that day on Monday 1/6. She stated the DON was busy and she was not sure the DON totally understood what she was talking about. She stated the DON told her that she would look into it.<br><br>On 1/21/25 at 2:30 PM, Staff D, CNA reported on 1/6/25 she had heard some noise coming from Resident #24's room and she went into the room to see if they needed any help. She stated Resident #24 was having his normal behaviors which was hitting and yelling. She stated Staff A, CNA and Staff B, RN were in the room and were either trying to get Resident #24's blood sugar or give medications. Staff D stated she was not sure which one but she knew something with nursing was taking place as Staff B was in the room. She stated she left the room and later returned to help Staff A transfer Resident #24 into the shower chair. Staff D stated later around lunch time Staff A had told her that the way Staff B was talking to Resident #24 made her uncomfortable. Staff D said she told Staff A that if it made her uncomfortable that she needed to report it. Staff D reported Staff A did not tell her what it was that Staff B had said that made her uncomfortable.<br><br>On 1/21/25 at 3:20 PM, The DON reported she found out about the allegations of abuse the day DIAL entered the facility for a complaint on 1/16/25. She reported that was why the date of the incident was uncertain. She stated initially she was told that the incident occurred the week before on a Thursday or Friday. She said during the facility investigation and staff interviews she identified the incident occurred on 1/6/25. She reported during the investigation she learned Staff A was in Resident #24's room getting him up for a bath. Staff B, RN came in the room and took his finger to do blood sugar, he struck out and she raised her hand. She stated the investigation was unclear on what Staff B had said in the room. She reported the location of the incident was also unclear. She stated at first it occurred at the nurses station, then in the Resident #24's room in the wheelchair and then in the room in the bed. She stated Staff B did not admit to anything. She said Staff B reported she has been in nursing for [AGE] years and had never raised a hand to a patient. When asked if Staff A had reported allegations of abuse to her, the DON stated no. She stated Staff A did not come to her office and if Staff A said anything in passing she did not hear it. The DON stated if something had been reported to her, she would have done something immediately and started an investigation. She stated the normal process was to separate/suspend, report to DIAL, start an internal investigation, and notify family/physician of the allegations.<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/22/25 at 7:20 AM, the Administrator reported she learned of the abuse allegations on 1/16/25. She stated she was out of the building and got a text that the nurse was being walked out and suspended. She stated the DON started the investigation on 1/16/25.<br><br>On 1/22/25 at 7:52 AM, the Administrator said she would expect staff to make sure the resident was safe and not in danger, report the allegations of abuse to the nurse or supervisor immediately, follow up/make sure the allegations were taken care of and if not tell someone else or report to the state themselves.<br><br>Review of the facility's internal investigation lacked documentation that the police were notified of the allegations of abuse.<br><br>On 1/22/25 at 4:30 PM, the Administrator reported the facility did not notify the policy of the allegations of abuse.<br><br>A facility policy title (facility name) Abuse Prevention, Reporting, Investigation Policy and Procedure revised April 2017 documented the residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. The administration and employees to take action to protect and prevent abuse and neglect from occurring within the facility by the following:<br><br>a. Not using verbal, mental, sexual and physical abuse, corporal punishment, or involuntary seclusion.<br><br>b. Not employing individuals who have been found guilty of abusing, mistreating individuals by a court of law and have had a finding entered into the State Nurse Aide Registry concerning abuse, neglect, and/or mistreatment of residents or misappropriation of their property.<br><br>c. Reporting any knowledge of actions by a court of law against an employee for service as a Nurse Aide, or other nursing facility staff to the State Nurse Aide Registry of Licensing Authorities.<br><br>d. Ensuring that all alleged violations involving mistreatment, neglect, or abuse including, injuries, injuries of unknown source, and misappropriation of resident property are reported to officials in accordance with Federal and State laws and also to the administrator, DON, and the Resident Services Director.<br><br>e. Providing evidence that all alleged violations are thoroughly investigated and thereby preventing further potential abuse while an investigation is in process.<br><br>f. Reporting results immediately to the State Survey Agency<br><br>g. Taking corrective action in cases where alleged abuse is verified.<br><br>The policy further documented in cases where there was suspected or known sexual/abuse or in incidents where there is serious physical injury or incidents of theft, law enforcement should be notified first and then other sources notified. In all cases, evidence should not be handled until law enforcement has arrived. |

| 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 | 01/23/2025 |

| 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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875<br><br>Based on staff interviews, facility investigation review, time card detail, and policy review the facility failed to separate a staff member from dependent residents accused of alleged physical and verbal abuse that occurred on 1/6/25 at 7:00 AM for Resident #24. The CNA (Certified Nursing Assistant) reported she told the DON (Director of Nursing) of the allegations of abuse later that afternoon on 1/6/25 and the DON denied being told or hearing of the allegation of abuse. The staff member worked full shifts on 1/6/25, 1/7/25, 1/9/25, 1/11/25, 1/12/25, 1/15/25 and a partial shift on 1/16/25. The facility investigation for the alleged abuse was initiated on 1/16/25 after DIAL (Department of Inspections, Appeals and Licensing) entered the facility and informed the DON of the alleged abuse. Two staff members interviews reflected inappropriate behavior with the nurse and Resident #24. The facility reported a census of 39 residents.<br><br>Findings include:<br><br>On 1/16/25 at 1:50 PM, Staff A, CNA reported last week either on Thursday or Friday around 7 AM, Staff B, RN (Registered Nurse) had gone to Resident #24's room to check his blood sugar. Resident #24 attempted to bite Staff B and Staff A helped stop him by grabbing his hand and when she did, he pulled his head away from Staff B. Staff B stated, If you bite me I will knock all the teeth out of your mouth and raised her hand to strike him. Staff A responded Hey and Staff B put her hand down. Staff A reported Staff D, CNA had come into Resident #24's room right after the incident because she had heard raised voices. Staff A reported she had told Staff D what had happened and Staff D told her that it was inappropriate and to tell the DON. Staff A reported it was a really busy day so she told the DON around 3 PM and the DON said she would deal with it. When asked if the DON had done anything, Staff A reported she never went back to follow up. Staff A reported she had worked the following weekend and Monday and Staff B had also worked the weekend. Staff A reported she had also told Staff E, CNA about the incident.<br><br>On 1/16/25 at 2:10 PM, Staff B, RN reported when she got angry she might say she wanted to hit something but had never said anything to a patient. Staff B stated she thought she should take up boxing to help her get rid of some frustrations. Staff B said she would never say she wanted to hit something in a patient's room, she stated she had said it at the desk. Staff B said she had been a nurse for [AGE] years and would never want to hit a patient.<br><br>Review of the document titled Intake revealed the facility filed allegation of abuse with DIAL for Resident #24 on 1/16/25 at 3:34 PM.<br><br>An Incident Report titled Alleged Neglect dated 1/16/25 at 5:18 PM documented a state official reported to nursing that a nursing staff yelled and raised a hand at Resident #24. The immediate action was that a staff member was suspended.<br><br>Review of Staff B Time Card Report dated 12/29/25 to 1/11/25 revealed Staff B worked full 12 hours shifts on 1/6/25, 1/7/25, 1/9/25 and 1/11/25.<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Staff B Time Card Reported dated 1/12/25 to 1/15/25 revealed Staff B worked full 12 hours shifts on 1/12/25 and 1/15/25. On 1/16/25 Staff B worked a partial shift and left the facility at 2:58 PM.<br><br>A hand written statement completed by Staff C, CMA (Certified Medication Aide) dated 1/16/25 documented he was down South and heard Staff B, RN say to Resident #24 if you hit me, I ' m going to smack you back. Staff C documented the incident happened in front of the nurses station where Resident #24 was parked before the staff brought him down for meals.<br><br>The untitled and unsigned facility investigation summary provided by the facility on 1/21/25 documented on 1/16/25 a state surveyor entered the building regarding a complaint against Staff B towards Resident #24. It was reported Staff B was reported to have an allegation of abuse and it was reported to the DON and nothing was done. The summary documented the incident had not been reported to the Administrator at any time. The summary revealed Staff B was suspended pending investigation on 1/16/25 when the DON was informed of the allegation and an incident report was filed with DIAL.<br><br>On 1/21/25 at 10:30 AM, Staff C, CMA reported the statement written on 1/16/25 was about a previous incident that had happened. Staff C reported he had heard Staff B say to Resident #24, if you hit me, I'm going to smack you back. He reported it happened when Staff B was trying to obtain Resident #24's blood sugar in front of the nurses station where Resident #24 sat before going down for meals. Staff C reported he did not say anything to anyone about what he had heard. He reported he did not think Staff B would actually hit someone. Staff C reported he did not think any other staff members were around or heard it. He said the aides were down the hallways. He reported Staff B claimed that she liked to joke around. Staff C stated he did not remember the exact date the incident happened but thought it was either on a weekend or a Friday as that was when he worked as a medication aide with Staff B. He reported Staff B does get frustrated at times. He said one time when the aides had reported a resident had fallen and Staff B was needed in the resident room, she said, God Damn and then slammed the medications down on the medication cart. Staff C also reported he had seen Staff B smack her fist down on the table when she got frustrated. He said Staff B does not like to work by herself and gets upset when there is not a second nurse.<br><br>On 1/21/25 at 11:31 AM, Staff E, CNA reported she had heard from Staff A, CNA that Staff A and Staff B, RN were getting Resident #24 up and Staff B said to Resident #24, I will knock out all of your damn teeth out of your mouth, if you try to bite me again. She said Staff A reported Staff B raised her right fist in the air. Staff A reported she thought it had happened on a Thursday and she heard about it the following day when she was working on 1/10/25. She reported Staff A told her that she had reported the incident to the DON. Staff E reported Staff B had been mean before. When asked what she meant by mean, Staff E stated Staff B was not directly mean to the residents but would talk about them at the nurses station.<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/21/25 at 12:45 PM, Staff A, CNA reported she had gone back, looked at the schedule and determined the incident occurred on Monday,1/6/25 as she was giving baths that day and Resident #24 was scheduled for the bath. She stated she took the bath chair into the room with her and was going to get him up. She stated Staff B, RN came into the room to get Resident #24 blood sugar. She stated Staff B leaned over Resident #24, grabbed his hand and he tried to bite her. Staff A reported Staff B told Resident #24, Don't you dare bite me, I am going to knock every tooth out of your mouth. She stated Staff B raised her right hand in the air like she was going to slap him but she did not. She stated Staff B did not explain what she was going to do prior to trying to get his blood sugar. Staff A reported she was able to get Resident #24 to calm down and he did let Staff B do the blood sugar. She stated Staff D, CNA heard noises coming from outside the room and she came in. Staff A reported she told Staff D what had happened. Staff A reported Staff B was at the nurses station later on repeating what she had said to Resident #24. Staff A reported she could not recall who else was sitting at the nurses station. She stated later that week, she thought on Friday,1/10/25, Staff E, CNA asked her about the incident so she told her what had happened. Staff A reported she had told the DON about the incident later that day on Monday 1/6/25. She stated the DON was busy and she was not sure the DON totally understood what she was talking about. She stated the DON told her that she would look into it.<br><br>On 1/21/25 at 2:30 PM, Staff D, CNA reported on 1/6/25 she had heard some noise coming from Resident #24's room and she went into the room to see if they needed any help. She stated Resident #24 was having his normal behaviors which was hitting and yelling. She stated Staff A, CNA and Staff B, RN were in the room and were either trying to get Resident #24's blood sugar or give medications. Staff D stated she was not sure which one but she knew something with nursing was taking place as Staff B was in the room. She stated she left the room and later returned to help Staff A transfer Resident #24 into the shower chair. Staff D stated later around lunch time Staff A had told her that the way Staff B was talking to Resident #24 made her uncomfortable. Staff D said she told Staff A that if it made her uncomfortable that she needed to report it. Staff D reported Staff A did not tell her what it was that Staff B had said that made her uncomfortable.<br><br>On 1/21/25 at 3:20 PM, The DON reported she found out about the allegations of abuse the day DIAL entered the facility for a complaint on 1/16/25. She reported that was why the date of the incident was uncertain. She stated initially she was told that the incident occurred the week before on a Thursday or Friday. She said during the facility investigation and staff interviews she identified the incident occurred on 1/6/25. She reported during the investigation she learned Staff A was in Resident #24's room getting him up for a bath. Staff B, RN came in the room and took his finger to do blood sugar, he struck out and she raised her hand. She stated the investigation was unclear on what Staff B had said in the room. She reported the location of the incident was also unclear. She stated at first it occurred at the nurses station, then in the Resident #24's room in the wheelchair and then in the room in the bed. She stated Staff B did not admit to anything. She said Staff B reported she has been in nursing for [AGE] years and had never raised a hand to a patient. When asked if Staff A had reported allegations of abuse to her, the DON stated no. She stated Staff A did not come to her office and if Staff A said anything in passing she did not hear it. The DON stated if something had been reported to her, she would have done something immediately and started an investigation. She stated the normal process was to separate/suspend, report to DIAL, start an internal investigation, and notify family/physician of the allegations.<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/22/25 at 7:20 AM, the Administrator reported she learned of the abuse allegations on 1/16/25. She stated she was out of the building and got a text that the nurse was being walked out and suspended. She stated the DON started the investigation on 1/16/25.<br><br>On 1/22/25 at 7:52 AM, the Administrator said she would expect staff to make sure the resident was safe and not in danger, report the allegations of abuse to the nurse or supervisor immediately, follow up/make sure the allegations were taken care of and if not tell someone else or report to the state themselves.<br><br>A facility policy titled (facility name) Abuse Prevention, Reporting, Investigation Policy and Procedure revised April 2017 documented the residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. The administration and employees to take action to protect and prevent abuse and neglect from occurring within the facility by the following:<br><br>a. Not using verbal, mental, sexual and physical abuse, corporal punishment, or involuntary seclusion.<br><br>b. Not employing individuals who have been found guilty of abusing, mistreating individuals by a court of law and have had a finding entered into the State Nurse Aide Registry concerning abuse, neglect, and/or mistreatment of residents or misappropriation of their property.<br><br>c. Reporting any knowledge of actions by a court of law against an employee for service as a Nurse Aide, or other nursing facility staff to the State Nurse Aide Registry of Licensing Authorities.<br><br>d. Ensuring that all alleged violations involving mistreatment, neglect, or abuse including, injuries, injuries of unknown source, and misappropriation of resident property are reported to officials in accordance with Federal and State laws and also to the administrator, DON, and the Resident Services Director.<br><br>e. Providing evidence that all alleged violations are thoroughly investigated and thereby preventing further potential abuse while an investigation is in process.<br><br>f. Reporting results immediately to the State Survey Agency<br><br>g. Taking corrective action in cases where alleged abuse is verified.<br><br>The policy further documented the alleged abuser will be immediately suspended from work pending the completion and results of the investigation, depending on the allegation. |

| 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 | 01/23/2025 |

| 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 0689<br><br>Level of Harm - 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** 49056<br><br>Based on clinical record review, staff interviews, and facility record review, the facility failed to provide adequate fall follow up and pain assessments after a fall for 1 of 1 residents reviewed (Residents #35). The facility reported a total census of 39 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) assessment dated [DATE] for Resident #35 documented diagnoses of non-Alzheimer ' s Dementia, non-traumatic brain dysfunction (a complex condition that occurs when the brain is damaged by internal factors, rather than an external force to the head), restlessness and agitation. The MDS showed the Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognition. The MDS revealed Resident #35 was independent with transfers, was substantial/maximal (helper does more than half the effort, helper lifts or holds trunk or lungs and provides more than half the effort) with upper and lower body dressing, and partial/moderate (helper does less than half the effort. helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) assistance with putting on/taking off footwear.<br><br>Review of facility reported incident dated 11/22/24 revealed Resident #35 was walking with staff around the living area and crossed one foot over the other and caught her sock/slipper and fell . Resident #35 bumped her head on the cabinet. Resident #35 was alert and disoriented at the time of the fall, which is her normal status. Resident #35 was assessed and assisted to a standing position, her sock/slippers were removed and gripper socks were applied. Review of the incident report under the predisposing situation factors improper footwear was not marked.<br><br>Review of resident Care Plan with initiated date of 11/13/24 intervention revealed to ensure that Resident #35 was to be wearing appropriate footwear when ambulating or mobilizing in a wheelchair and required the assistance of one staff member for dressing.<br><br>Review of resident Care Plan with initiated date of 11/22/24 intervention revealed to wear gripper socks or shoes when up.<br><br>Review of facility Progress Notes revealed the facility failed to assess resident after the fall on these dates:<br><br>On 11/22/24 at 16:45 PM revealed that Resident #35 refused to allow staff to do neurological assessment.<br><br>On 11/22/24 at 19:59 PM revealed Resident #35 refused blood pressure (BP) to be taken for a fall neurological assessment.<br><br>On 11/22/24 at 23:45 PM revealed Resident #35 refused BP to be taken.<br><br>On 11/23/24 at 19:50 PM revealed Resident #35 had no behaviors reported as of this time.<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 11/23/24 at 23:46 PM revealed Resident #35 refused BP to be taken.<br><br>Review of facility Follow Up Assessment revealed on:<br><br>On 11/23/24 at 11:46 PM this assessment was incomplete.<br><br>On 11/23/24 at 1:20 AM this assessment was incomplete.<br><br>On 11/24/24 at 10:53 PM this assessment was incomplete.<br><br>On 11/25/24 at 7:55 AM this assessment was incomplete.<br><br>Review of facility provided document titled Fall Risk Assessment for Resident #35 dated 11/6/24 scored a 5 indicating moderate risk for falls.<br><br>Review of facility provided document titled Fall Risk assessment dated [DATE] scored a 9 indicating moderate risk for falls.<br><br>Review of facility provided document titled Fall Risk assessment dated [DATE] scored a 20 indicating high risk for falls.<br><br>Review of Progress Notes dated 11/27/24 at 4:58 AM revealed Resident #35 was wandering in the hallway crying and awakening peers. Resident #35 sits on her bed rocking back and forth and grabbing at imaginary items on the floor. Resident #35 refuses to answer staff when questioned and is inconsolable. The staff walked with the Resident #35 and encouraged her to communicate why she is crying. Resident #35 continued to sit on bed rocking back and forth and not responding to staff at this time.<br><br>Review of Progress Notes dated 11/29/24 at 10:04 AM revealed Resident #35 complained of right leg pain.<br><br>Review of Progress Notes dated 11/30/24 at 3:44 PM revealed Resident #35 does seem to be having pain but unable to identify where pain is located. Resident #35 is utilizing two staff for assistance with transfer.<br><br>Review of Progress Notes dated 12/1/24 at 12:45 PM revealed Resident #35 appears to have pain but unable to identify where pain is located. Resident #35 was given as needed acetaminophen which seemed effective.<br><br>Review of Progress Notes dated 12/2/24 at 10:46 AM revealed Resident #35 had been having right leg pain, no bruising, redness, swelling, no rotation to her leg noted. Resident #35 needed help to get out of bed and chairs. Resident #35 needed assistance from one person for walking. Resident #35 does not want to place all of her weight on her leg. Resident #35 does have a limp and has facial grimacing when getting up. States the longer she walks the steadier and even her gait is. Resident #35 had been walking independently prior to the leg pain. Resident #35 has been utilizing her as needed acetaminophen. A fax was sent to the physician.<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the MD/Nursing Communication form on 12/2/24 at 10:51 AM was a copy of the progress note as above. The communication to the physician lacked notification that Resident #35 had fallen previously.<br><br>Review of Progress Notes dated 12/2/24 revealed the facility received orders for a physical therapy referral for right leg pain.<br><br>Review of Progress Notes dated 12/3/24 at 9:44 AM revealed Resident #35 had been walking with assistance of one staff person. Resident #35 continued to complain of pain to her right leg. Staff gave as needed acetaminophen to help with the pain.<br><br>Review of the Physical Therapy Treatment Encounter note dated 12/5/24 revealed Resident #35 was having a very hard time weight bearing on the right lower extremity and having a lot of facial grimaces and grabbing of the right hip. Resident #35 limited in her hip active and passive range of motion due to pain and requires a moderate assist of 2 staff members. Physical Therapy recommends nursing staff get a hold of the doctor for the x-ray of her right hip due to her fall and presentation today.<br><br>Review of Progress Notes dated 12/5/24 at 3:21 PM revealed a fax was sent to the physician requesting an order for an x-ray of the right leg per request of Physical Therapy (PT).<br><br>Review of Progress Notes dated 12/6/24 at 12:25 PM revealed the facility received an order for Resident #35 to have an x-ray of her right leg, at 2:46 PM the facility received the results of the x-ray. Review of the x-ray report dated 12/6/24 revealed a mildly displaced subcapital right femoral neck fracture. At 3:45 PM Resident #35 was transferred to the emergency room and admitted to the hospital to have right hip surgery.<br><br>On 1/23/25 at 11:45 AM interview with Staff H, Licensed Practical Nurse (LPN) revealed that Resident #35 didn't complain of pain right away. Staff H revealed she wasn't working when she started to complain of pain.<br><br>On 1/23/25 at 12:15 PM interview with Staff B, Registered Nurse (RN), revealed that she was called into the unit and the staff stated someone was walking with Resident #35 and she bumped her head on the cabinet. Staff B revealed that she was sitting on the floor with her back against the wall. Staff B revealed that she did an assessment on Resident #35 and assisted her off the floor. Staff B stated that Resident #35 was able to ambulate at that time and did not show any signs of pain. Staff B stated that they are to do fall documentation on every shift times 8 shifts and if it is an unwitness fall, they are to do neurological assessments every 15 minutes x 4, every 30 minutes x 4, every 1 hour x 4 and every 4 hours x 4. Staff B stated that they are also to do a Skilled Nursing Facility (SNF) nursing note and notify physician and family.<br><br>On 1/23/25 at 2:00 PM Staff C, Certified Medication Aid (CMA)/Certified Nursing Assistant (CNA) and Staff G, CNA, revealed that if they would try to move Resident #35 she wouldn't be able to stand, they don' t remember any crying episodes. They don't remember when she started showing signs of pain. They stated they reported it to the nurse and they stated the nurse gave her pain medication and would notify the physician.<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 1/23/25 at 10:30 AM the Director of Nursing (DON) revealed the facility did not to an internal investigation regarding Resident #35's right hip fracture. The DON revealed her expectation would be to have nursing staff do follow up fall documentation for 72 hours and to document pain, and anything that is different than the normal for the resident, if gait is steady.<br><br>On 1/23/25 at 2:00 PM the MDS Coordinator revealed the expectation is to document and assess the resident, talk to staff and see what may have prevented the fall. Staff are to document every shift for 72 hours. Staff are to do neuro's if the fall was unwitnessed and if the resident is refusing neuro's to notify the physician. Staff are to document range of motion, gait, ambulation, and vital signs. If there is a change in condition, the expectation would be to notify the physician. Staff are to document the interventions for the fall. The MDS Coordinator revealed that Resident #35 had fuzzy socks on due to family bringing them in so they had them removed and educated staff. The MDS coordinator stated that new interventions get passed on in the huddles during the morning and afternoon shifts from the communication sheets and staff also have access to the kardex in the electronic health record.<br><br>Review of the undated facility policy titled Fall Policy revealed:<br><br>Immediate Response:<br><br>Upon discovery of a fall: do not move resident until vital signs and range of motion (ROM) are done.<br><br>Assessment: Immediate resident assessment:<br><br>Take vital signs<br><br>Note any ROM issues and complaints of pain.<br><br>Treat any injuries<br><br>Use a lift for extensive assistance<br><br>Call for an ambulance if needed<br><br>Complete Neuro checks for unwitnessed falls<br><br>Complete Risk Management Report<br><br>Follow up Actions:<br><br>Unusual Occurrence Assessment:<br><br>Initiate a skin sheet if there's an injury.<br><br>Follow up after fall:<br><br>Conduct follow ups every shift for 72 hours (include interventions and pain assessment)<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Care plan update:<br><br>Update the care plan to reflect new interventions.<br><br>Communication:<br><br>Notifications:<br><br>Inform the Family, Director of Nursing (DON), Administrator, and Physcian |

| 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 | 01/23/2025 |

| 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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<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 ensure residents on antibiotics were re-evaluated for excessive duration, for 2 of 3 residents reviewed (Resident #7 and #8). The facility reported a census of 39 residents.<br><br>Findings include:<br><br>According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #7 scored 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident had diagnoses including cardiorespiratory conditions and anxiety.<br><br>The Care Plan revised 5/7/24 identified Resident #7 on routine antibiotic therapy for preventative measures secondary to a history of chronic urinary tract infections (UTI's). Interventions included administering medication as ordered, and taking Cephalexin daily at bedtime for prevention. Antibiotics were non-selective and may result in the eradication of beneficial microorganisms and the emergence of undesired ones, causing secondary infections such as oral thrush, colitis, and vaginitis. Observe the resident for possible side effects to antibiotic therapy.<br><br>The Medication Administration Record (MAR) for January 2025 showed Resident #7 on Cephalexin 500 mg 1 capsule by mouth at bedtime for prevention related to UTI, with a start date of 4/23/22.<br><br>The resident's clinical record lacked documentation the physician had re-evaluated the antibiotic for continued use.<br><br>On 1/22/25 at 8:02 a.m. Resident #7 stated she had 3 bladder surgeries and went through a very difficult time. She had UTI's and drank a lot of cranberry juice. She had not had a UTI in awhile. She said she could not say what medications she took. She did not know if she took an antibiotic.<br><br>On 1/23/25 at 8:48 a.m. the Pharmacy Consultant stated some people go on prophylactic antibiotics long term and some for the rest of their lives. He said the prophylactic antibiotic dose was usually a lower dose of 250 mg of Cephalexin. He would look into the residents dose of 500 mg. He had not been looking at the long term antibiotics with his med reviews.<br><br>On 1/23/25 at 2 p.m. the Infection Preventionist (IP), stated she started in December of 24. She looked at Resident #7's record and the Cephalexin had not been reviewed in the last year.<br><br>The undated facility Antibiotic Stewardship for Nursing Homes information documented up to 70% of nursing home residents received one or more systemic antibiotics every year. Studies showed that 40-75% of antibiotics used in nursing homes may be unnecessary or inappropriate. Risks of impairment from antibiotic overuse were high for older adults residing in nursing homes. Potential risks included infections, adverse drug reactions and colonization or infection with antibiotic-resistant organisms.<br><br>49056<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #6 documented diagnoses of anxiety, schizophrenia, seizure disorder, and heart failure. The MDS showed a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition.<br><br>Review of the Care Plan with a revision date of 2/22/24 revealed Resident #6 on antibiotic therapy prophylactically related to history of frequent urinary tract infections and to monitor/document for side effects and effectiveness.<br><br>Review of the Physician Orders revealed Resident #6 started on the prophylactic antibiotic on 10/19/23.<br><br>Review of the facility Progress Notes revealed Resident #6 was to have a urology appointment on 5/5/2024. The Director of Nursing acknowledged and verified that Resident #6 did not go to this appointment and she wasn't sure why. |

| 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 | 01/23/2025 |

| 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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>46875<br><br>Based on observations, clinical record review and policy review the facility failed to give medications according to manufacturer's instructions for 1 out of 6 residents observed during medication pass (Resident #8). The facility reported a census of 39 residents.<br><br>Findings include:<br><br>The Minimum Data Set (MDS) assessment for Resident #8 dated 1/13/25 identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS identified Resident #8 was independent with bed mobility, transfers and walking. The MDS included diagnoses of cerebral palsy, non-alzheimer's dementia, seizures and moderate intellectual disabilities.<br><br>The January 2025 Medication Administration Record (MAR) directed staff to administer Fosamax (used to treat or prevent osteoporosis) 70 MG (milligrams) one tablet by mouth one time a week in the AM on Thursday related to specified disorders of bone density and structure. The order lacked specific directions on how the medication should be administered.<br><br>On 1/23/25 at 7:58 AM, observed Resident #8 sitting at the dining room table and she had finished eating her breakfast. Staff F, CMA (Certified Medication Aide) prepared Resident #8 morning medications which included the Fosamax. The CMA administered all the medications at the dining room table with a glass of water. Staff F verified Resident #8 had finished eating breakfast when the Fosamax was given along with the other medications. Staff F reported the January MAR directed the Fosamax to be given during AM medication pass. The CMA reported sometimes Resident #8 will take her medications in her room before breakfast and other times take them in the dining room during or after breakfast.<br><br>During observation with the morning medication pass on 1/23/25 with Resident #8 and review of January 2025 MAR revealed the following medications were given at the same time as the Fosamax:<br><br>-Levothyroxine Sodium (treat hypothyroidism) 50 MCG (Micrograms). The Levothryroxine was scheduled on the January 2025 MAR as Early and according to manufacturer's guidelines was also to be given on an empty stomach.<br><br>-Calcium Carbonate (antacids) 2 tablets in the morning for an upset stomach.<br><br>-Ferrous Sulfate (Iron supplement) 325 MG one tablet in the morning.<br><br>-Fluoxetine HCL (Antidepressant) 30 MG in the morning.<br><br>-Vitamin D3 (supplement) 2000 IU (international units) in the morning.<br><br>-Lamotrigine 25 MG 2 tablets in the morning for seizures.<br><br>- Myrbetriq Extended Release 50 MG in the morning for overactive bladder.<br><br>-Omeprazole Delayed Release 20 MG in the morning every other day for vomiting.<br><br>(continued on next page) |

| 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 | 01/23/2025 |

| 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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Phenytoin Sodium Extended 100 MG in the morning for seizures.<br><br>-Multivitamin with minerals (supplement) 1 tablet in the morning.<br><br>The Fosamax medication manufacturer's instructions instructed patients to swallow the medication whole with 6 to 8 ounces plain water at least 30 minutes before the first food, drink or medication of the day and not to lie down for at least 30 minutes after taking the medication and until after food. The manufacturer's instructions documented calcium supplement, antacids, vitamins or other oral medications can interfere with the absorption of the Fosamax.<br><br>On 1/23/25 at 8:30 AM, the DON (Director of Nursing) reported she would expect the Fosamax medication to be given 1/2 hour before eating or taking any other medications and to sit up right 1/2 hour after taking the medication.<br><br>An undated facility policy titled Medication Disbursement Policy documented the purpose of the policy was to establish guidelines to promote the health and safety of persons served by ensuring the safe assistance and administration of medication and treatments or other necessary procedures. The policy further documented that staff administering medication must know or be able to locate medication information on the intended purpose, side effects, dosage and special instructions. The policy directed staff to compare the medication sheet with the label of each medication for the following: right person, right medication, right time, right date, right route, right dose, and right expiration date. |

| 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 | 01/23/2025 |

| 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 0851<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.<br><br>26527<br><br>Based on personnel time card records and staff interview, the facility failed to electronically submit to the Centers for Medicare and Medicaid Services (CMS) complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data. The facility reported a census of 39 residents.<br><br>Findings include:<br><br>The facility Payroll Based Journal (PBJ) Staffing Data Report for fiscal year quarter 4 2024 (July 1 - September 30) showed an area of concern triggered. The facility failed to have licensed nursing coverage 24 hours a day on 7/5, 7/6, 7/7, 8/2, 8/10, 8/11, 8/15, 8/24, 8/25, 9/7, 9/8, and 9/22/24.<br><br>The facility provided time card information for facility staff working the days above, and agency staffing invoices documenting agency staff working the same day above, showing the facility had a nurse on 24 hours per day.<br><br>On 1/22/25 at 5:02 p.m. the Administrator provided documentation they had 24 hour staffing on the days that were lacking on the PBJ report. She understood this needed to be reported accurately. |