STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165135	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STRAWBERRY POINT LUTHERAN HOME	**313 ELKADER STREET STRAWBERRY POINT, IA 52076**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review the facility failed to report 3 of 9 incidents reviewed involving 4 of 5 residents (Residents # 1, 2, 3, and 4). The facility identified a census of 16 residents. 1. The facility's Online Abuse or Incident Reporting List showed the following reports: - 3/9/20 for Allegation of Abuse. - 3/26/20 for Allegation of Abuse. - 4/4/20 for Allegation of Abuse. - 6/11/20 for Allegation of Abuse. -7/16/20 for Allegation of Abuse. The facility's Incident/Investigation Reports were dated as followed: - 3/9/20- reported. - 3/17/20- records showed an incident witnessed, not written up, investigated, or reported. - 3/26/20- reported. - 4/4/20-reported. - 4/16/20-not reported but witnessed for inappropriateness. - 4/20/20- not reported for a physical encounter witnessed. - 6/11/20-reported. - 7/3/20- not reported, as determined a fall in another resident's room. - 7/16/20- reported. The quarterly assessment Minimum Data Set (MDS) for Resident #1 dated 5/27/20 listed [DIAGNOSES REDACTED]. The MDS documented a BIMS score of 1 out of 15 which indicated severe impairment with cognitive skills, limited staff assistance with ambulation, had behaviors including physical aggression, verbal aggression not directed at others and experienced delusions and hallucinations. The Minimum Data Set (MDS) quarterly assessment dated [DATE] for Resident #2 identified the resident with a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated severe impairment with cognitive skills. The MDS documented the resident with [DIAGNOSES REDACTED]. The MDS documented the resident as independent with ambulation, had inattention and disorganized thinking. The resident's behaviors including physical aggression, verbal aggression directed at others and experienced delusions and hallucinations Resident #3's MDS quarterly assessment dated [DATE] documented the resident with a BIMS score of 15 out 15 which indicated no cognitive impairment skills, had delusions and verbal behavior directed at others, and independently mobile on the unit with the use of a wheelchair. The MDS listed [DIAGNOSES REDACTED]. Resident #4's MDS quarterly assessment dated [DATE] documented the resident with a BIMS score of 2 out of 15 which indicated severe cognitive impairment with disorganized thinking. Resident #4 was independent with ambulation. The MDS showed the resident had [DIAGNOSES REDACTED]. During an interview on 8/3/20 at 11 a.m., Staff A, Certified Nursing Aide (CNA), reported that on 3/17/20 she saw Resident #2 put both hands to Resident # 4' s neck and pushed the resident fully extending the arms outward. Resident #4 hit the Nursing station wall and fell down to the floor on the buttocks. There were no injuries. Staff B, Licensed Practical Nurse (LPN) was inside the nursing station working on the computer and did not see the incident. The Acting Administrator had also been in the unit. The CNA reported filling out a statement and handing it to the Nurse, Staff B. She did not know if this had been reported to the state. Staff A reported the Administrator, also present, had stated to her that didn't happen. During an interview on 8/4/20 at 3:17 p.m., Staff B stated she did not see this incident between Resident #2 and Resident #4 and doesn't believe Resident # 4 fell . Staff B stated she did not receive a written statement from Staff A regarding what she has seen. Staff B stated that after discussing the incident with the Acting Administrator, who had conferred with the Director of Nursing (DON), they concluded that Resident #2 had only directed Resident #4 away from the doorway of the room (#15). The Acting Administrator and DON decided this did not need to be investigated, thus no incident report needed to be written nor reported to the state. Staff B did not know if it should have been a reportable incident. During an interview on 8/5/20 at 11:45 a.m., the Acting Administrator stated that on 3/16/20 Staff B sat inside the nursing station charting while she stood right outside of the nursing station. She reported Staff A had been in another resident's room (right behind where she stood) and does not understand how Staff A could have seen Resident #2 push Resident #4, as she had been in another resident's room. She also noted she did not know if Resident #4 fell or not. She did note Staff A hustled over to where the 2 residents were in front of room [ROOM NUMBER], in the hall. The Acting Administrator reported it should have been reported as an incident and investigated and thought it had been, but was unable to produce the report. She stated she expected the charge nurse to write up an investigation report and the DON would follow up on it. During a telephone interview on 5/5/20 at 1:20 p.m., with the DON, she reported the Acting Administrator called her at home regarding the event on 3/17/20 between Resident #2 and Resident #4. The DON did not know if a push had occurred with the 2 residents, as she had received a report from the Acting Administrator. She knew Staff A separated the 2 residents involved. The DON did not know if Staff B or the Acting Administrator talked with Staff A , regarding Staff A's account of what had happened. She noted Staff B and The Acting Administrator did not know if Resident #2 actually touched Resident #4 when Resident #4 fell . The DON commented if the resident fell an incident report should have been filed, but stated she did not remember if one had been filed. The facility's Investigation Report dated 4/16/20 showed the nurse was called to the room by a Certified Nursing Aide (CNA) to find Resident #2 sitting next to Resident # 1's on the bed with his/her pants pulled down to the knees, exposing the groin area. Resident #1 stated I was just rubbing her/his back. There were no injuries identified. During an interview on 8/3/20 at 3:30 p.m. the Acting Administrator acknowledged this incident on 4/16/20 regarding Resident #1 and Resident #2 could be seen as exploitation and should have been reported. The Acting Administrator looked at the facility's Resident to Resident Abuse policy (dated 4/13/17) involving reporting which included exploitation and said this incident appeared as exploitation. During a telephone interview on 8/5/20 at 1:20 p.m., the DON reported she did not see this incident on 4/16/20 as exploitation, but in hindsight it would be and she should have reported this incident to the state. She reported she used the Flow Chart of Required Abuse Reporting in Facility Involving Resident from Iowa Health Care Association (IHCA) to determine if this incident should be reported. The facility's Investigation Reported 4/20/20 showed a CNA witnessed Resident #2 reach out and grabbed Resident #3's neck with their hand. There were no marks noted to the neck area. Resident #3 reported of being ready to hit the other resident with their cane. The DON's conclusion for this report, determined with the use of using Iowa Health Care Association's (IHCA) guidelines, that this event did not need to be reported to the state. During an interview on 8/3/20 at 3:30 p.m., the Acting Administrator stated the incident on 4/20/20 in which Resident #3 had stated they were ready to hit Resident #2 with a cane, could be seen as mental anguish. She noted the facility's Resident to Resident Abuse (dated 4/13/17) involved reporting abuse included the definition as causing a resident mental anguish. During an interview on 8/4/20 at 11:45 a.m., the Acting Administrator stated she expected the DON to follow up with all incidents by implementing interventions, communicating to staff, and calling the families. She stated she and the DON will typically confer about the incident and she usually makes the report to state. She stated they both can notify the state, depending on each of their availability. The Acting Administrator stated they both can complete the conclusions for the findings on the Incident Reports. During a telephone interview on 8/5/20 at 1:20 p.m., the DON reported she didn't see the CNA's witness statement until later and she should have investigated this incident more and reported it to the state. The DON stated with the use of using Iowa Health Care Association's (IHCA) guidelines this event did not need to be reported to the state. During an interview on 8/12/20 at 8:33 a.m., the DON reviewed the IHCA's guidelines and

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

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.

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) referred to the part that gave directions for no reporting if there were no physical injury and a cognitively intact resident is able to say they experience no pain or mental anguish (reasonable person standard). The DON stated the incident between Resident #2 with #3, in which Resident #3 can be lucid at times, she did not feel needed to be reported. When pointed out the other incidents not reported were between 2 residents who did not have intact cognitive skills, the DON stated she did not know why she concluded those incidents did not have to reported to state. The IHCA Flow Chart of Required Abuse Reporting in Facility involving Resident, the facility answered their questions as the following: - was there evidence of victim resident experiencing pain or mental anguish or physical harm (injury). CMS (Center for Medicare/Medicaid Services) presumes that instances of abuse cause physical harm or pain or mental anguish (absent objective evidence to the contrary), but if in doubt, report. - no reporting required if no physical injury and cognitively intact resident able to say no pain or mental anguish (reasonable person standard). The facility's Resident to Resident Prevention, Identification, Investigation, and Reporting Policy dated 7/30/17 stated their Purpose included all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The Policy also defined Abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The Policy also defined Resident to Resident physical contact that occurs, which includes but is not limited to where residents are hit, slapped, pinched or kicked and result in physical harm, pain, or mental anguish is considered resident to resident abuse. The facility will presume that instances of abuse cause physical harm, or pain or mental anguish in residents with cognitive and/or physical impairments which may result in a resident being unable to communicate physical harm, pain or mental anguish, in the absence of evidence to the contrary.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview, and record review the facility failed to thoroughly investigate allegations of resident to resident altercations for 2 of 9 incidents reviewed involving 3 of 5 residents involved (Resident # 2, 3, and 4). The facility identified a census of 16 residents. Findings include: 1. Resident #2's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented the resident with a Brief Interview for Mental Status (BIMS) score of 3 which indicated severely impaired cognitive ability. The MDS documented the resident as independent with ambulation, and had problems with inattention and disorganized thinking. The resident's behaviors including physical aggression, verbal aggression directed at others and had delusions and hallucinations. The MDS documented the resident had [DIAGNOSES REDACTED]. The facility's Investigation Reported 4/20/20 documented a Certified Nurse's Aide (CNA) witnessed Resident #2 reach out with their hand and grab Resident #3's neck. There were no marks noted to the neck area. Resident #3 reported being ready to hit the other resident with their cane. The Director of Nursing (DON) stated she used the Iowa Health Care Association's (IHCA) guidelines and concluded this event did not need to be reported to the state. Three days later on 4/23/20, the DON added the statement to the investigation report finding the written statement from the CNA, who witnessed the incident. The DON wrote the written statement had not been the same as it had been reported to her. The DON also wrote Resident #3 had told the nurse (Staff D) Resident #2, had not touched him, and if that had happened Resident #3 would hit Resident #2 with the cane. There were no further investigation or interviews, written statements with Staff D, Staff E, and Resident #3 completed by the DON to verify this incident. During an interview on 7/30/20 at 10:25 a.m., Resident #3, who is documented with Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated no impairment in cognitive skills, sat in a wheelchair holding a cane. The resident stated that back in April 2020 Resident #2 took their hand and squeezed her/his throat. The resident expressed feeling threatened with harm and asked the surveyor, wouldn't you if someone grabbed you by the throat? Resident #3 reported Staff E, Certified Nursing Aide (CNA), saw it happen and come right over and stood between them. Record Review of the Nurse's Notes dated 4/20/20 showed Staff D, Licensed Practical Nurse (LPN) documented the incident. Staff D reported Resident #3 reported Resident #2 placed their hand around Resident #3's neck and Staff E witnessed the encounter. There were no injuries or marks and Resident #3 remarked if the hand had been any tighter, he/she would hit the resident in the groin area with the cane in hand. Staff D received Staff E's written statement and also wrote in the note to 'see the witness statement'. During an interview on 8/3/20 at 7:50 a.m., Staff E stated Resident #2 had been agitated that day in April. She saw Resident #3 in front of the room, closing the door, going out for supper. Resident #2 came up and reached his/her hand to Resident #3's throat. When Staff E saw Resident #2 reaching toward Resident #3's neck she hollered out 'don't touch' the resident. Resident #3 told her of being ready to hit Resident #2 in the groin with the cane. Staff E reported writing up the statement for the DON. During an interview on 8/3/20 at 3:30 p.m., the Acting Administrator stated the incident on 4/20/20 revealed Resident #3 had stated they were ready to hit Resident #2 with a cane and this could be seen as mental anguish. She noted the facility's Resident to Resident Abuse (dated 4/13/17) involved reporting abuse included the definition as causing a resident mental anguish and this incident should have been reported to the state. She reported her and the DON use the Iowa Health Associations guidelines for reporting abuse. During a telephone interview on 8/5/20 at 1:20 p.m., the DON reported she didn't see the CNA's witness statement until later and should have investigated this incident more and reported it to the state. The DON stated she interviewed Resident # 3 who denied that Resident #2 touched him/her, but also stated they were ready to hit the other resident if needed. The DON stated she failed to write up that statement. The DON stated Resident #3 can embellish stories at times. The DON stated according to the Iowa Health Care Association's (IHCA) guidelines for reporting this event, which they refer to, the incident did not need to be reported to the state. During an interview on 8/12/20 at 8:36 a.m., the DON reviewed the IHCA's guidelines and referred to the part that gave directions for no reporting if there were no physical injury and a cognitively intact resident is able to say there was no pain or mental anguish (reasonable person standard). The DON stated the Incident between Resident #2 with #3, in which Resident #3 can be lucid at times, was not felt needed to be reported. When noting the other incidents that were not reported were between 2 residents who did not have intact cognitive skills, the DON stated she did not know why she concluded those incidents did not have to be reported. She acknowledged both residents, Resident #2 and #4 were cognitively impaired. The IHCA Flow Chart of Required Abuse Reporting in Facility involving Resident, the facility refers toward the end of answering their questions the following: - was there evidence of victim resident experiencing pain or mental anguish or physical harm (injury)? CMS (Center for Medicare/Medicaid Services) presumes that instances of abuse cause physical harm or pain or mental anguish (absent objective evidence to the contrary), but if in doubt, report. - no reporting required if no physical injury and cognitively intact resident able to say no pain or mental anguish (reasonable person standard). The facility's Resident to Resident Prevention, Identification, Investigation, and Reporting Policy dated 7/30/17 stated their Purpose included all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The Policy also defined Abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The Policy also defined Resident to Resident physical contact that occurs, which includes but is not limited to where residents are hit, slapped, pinched or kicked and result in physical harm, pain, or mental anguish is considered resident to resident abuse. The facility will presume that instances of abuse cause physical harm, or pain or mental anguish in residents with cognitive and/or physical impairments which may result in a resident unable to communicate physical harm, pain or mental anguish, in the absence of evidence to the contrary. 2. Resident #4's MDS quarterly assessment dated [DATE] documented the resident with a BIMS score of 2 which indicated severe cognitive impairment. The MDS documented the resident with disorganized thinking and independent with ambulation. The MDS listed [DIAGNOSES REDACTED]. Record Review for the Nurse's Notes in Resident's 4's chart failed to identify any altercation on 3/17/20 with another resident. Record Review of Resident #2's chart documented the resident had continued receiving new medications. At approximately 4:50 p.m. on 3/27/20, Resident #4 became agitated and was yelling at another resident for being by Resident #2's doorway. The two residents were separated. During an interview on 7/29/20 at 1:10 p.m., Staff D, LPN, also the MDS Coordinator and designated Social Worker, reported being informed by staff of an incident which occurred on 3/17/20 between Resident #2 and Resident #4 but did not know if this had been reported to state. She reported she had not been present but allegedly Staff A, CNA, reported

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) seeing an altercation between the residents where Resident #2 pushed Resident #4 down by room [ROOM NUMBER]. Staff A reported the protocol for resident to resident altercations is to separate, assess and add interventions as needed and to notify their supervisors. During an interview on 8/3/20 at 11 a.m., Staff A, Certified Nursing Aide, stated on 3/17/20 she witnessed Resident #2 put both hands to Resident # 4' s neck and pushed the resident fully extending their arms outward. Resident #4 hit the Nursing station wall and fell down to the floor on the buttocks. There were no injuries noted. Staff B, Licensed Practical Nurse(LPN) was inside the nursing station working on the computer and did not see the incident. The Acting Administrator had also been in the unit. The CNA stated she filled out a statement and handed it to the Nurse, Staff B. She did not know if this had been reported to the state. Staff A stated the Administrator who was also present had stated to her that didn't happen in regards to the fall. During an interview on 8/4/20 at 3:17 p.m., Staff B, LPN, stated she did not see this incident between Resident #2 and Resident #4 and doesn't believe Resident # 4 fell . Staff B did not receive a written statement from Staff A regarding what she had seen. Staff B commented after discussing the incident with the Acting Administrator, who conferred with the Director of Nursing (DON), they concluded Resident #2 only directed Resident #4 away from the doorway of the room (#15). The Acting Administrator and DON decided this did not need to be investigated, thus no incident report needed to be written nor reported to the state. Staff B did not know if it should have been a reportable incident. Durig an interview on 8/5/20 at 11:45 a.m,. the Acting Administrator reported on 3/16/20 Staff B sat inside the nursing station charting while she stood right outside the nursing station. She reported Staff A had been in another resident's room (right behind where she stood) and does not understand how Staff A could have seen Resident #2 push Resident #4, as she had been in another resident's room. She also noted she did not know if Resident #4 fell or not. She did note Staff A hustled over to where the 2 residents were in front of room [ROOM NUMBER], in the hall, and separated them. The Acting Administrator reported it should have been reported as an incident and investigated and she thought it had been, but was unable to produce the report. She stated she expected the charge nurse to write up an investigation report and the DON would follow up on it. During a telephone interview on 5/5/20 at 1:20 p.m., with the DON stated the Acting Administrator called her at home regarding the event on 3/17/20 between Resident #2 and Resident #4. The DON did not know if a push had occurred with the 2 residents, as the Acting Administrator had reported. She knew Staff A separated the 2 residents involved. The DON did not know if Staff B or the Acting Administrator talked with Staff A , regarding Staff A's account of what had happened. She noted Staff B and the Acting Administrator did not know if Resident #2 actually touched Resident #4 when Resident #4 fell . The DON commented if the resident fell an incident report should have been filed, noting she did not remember if one had been filed. During a telephone interview on 8/10/20 at 11:11 a.m., Staff B did not recall receiving a written statement from Staff A, but stated if she had she would have given it to the Acting Administrator who had been present. Staff B does not remember talking with Staff A, who witnessed the incident. Staff B reported after the Acting Administrator had conferred with the DON, they decided Resident #2 only re-directed the resident away from the room, and not to write up any incident report. Staff B reported hearing Resident #4 make a noise and saw Staff A separating the 2 residents. She also commented if Resident #4 had been on the floor, she would have written up an incident report, but did not believe she had fallen. During an interview on 8/12/20 at 8:37 a.m., the Acting Administrator stated Staff A did not write up a statement and she did not ask her to. If Staff A did witness what she said she did, then she probably should have had her write up a statement. The Acting Administrator stated she did consult with the rest of the staff and no one else had seen the altercation. The Acting Director, the DON, and Staff B just agreed there had not been an incident.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review the facility failed to identify and provide adequate interventions to ensure that residents were safe from harm from other residents. The facility continued to provide 15 minute checks for Resident #2, yet after that implementation on 3/25/20, the Resident had 4 more incidents/altercations with other residents. The facility identified a census of 16 residents. Findings include: 1. Resident #2's Minimum Data Set (MDS) quarterly assessment dated [DATE] identified the resident with severe cognitive impairment. The MDS documented the resident as independent with ambulation, and experienced inattention and disorganized thinking. The resident's behaviors included physical and verbal directed at others. The resident experienced delusions and hallucinations. The MDS documented the resident with [DIAGNOSES REDACTED]. Review of a Care plan dated 3/2/20 showed Resident #2 had a behavior problem related to dementia. The following interventions for this concern included: - Revised on 3/9/20: assist the resident to develop more appropriate methods of coping and interacting with staff and peers and encourage the resident to express feelings appropriately. - intervene as necessary to protect the rights and safety of others. - approach/speak in a calm manner, divert attention and remove the resident from situation and take to an alternate location as needed. The resident can be very territorial and protective of what belongs to him/her. - Revised on 6/12/20: the Resident's second spouse looks similar to Resident #4 (bad marriage) and this may be a trigger for the resident. - Revised on 3/27/20: minimize potential for the resident's disruptive behaviors (yelling/screaming) by offering to talk about baseball (Cardinals), Willie Nelson, or Iowa Wrestling which diverts attention. - Revised on 3/9/20: provide a program of activities that is of interest and accommodates the residents status such as the Cardinals, Ted Williams, Iowa wrestling, Dan Gable, Willie Nelson, Johnny Cash and horses. - Revised on 7/17/20: the resident is to be monitored by the nurse and when the nurse is not available she is to assign a staff member to monitor in her absence and continue to document on 15 minute check sheets, redirect the resident when approaching others personal space (related to territorial behaviors and post traumati[DIAGNOSES REDACTED] disease). The Care Plan also revised on 4/16/20 showed the resident had a problem as an elopement risk, wandered aimlessly, significantly intrudes on privacy or activities. Interventions for this concern included: - distract the resident from wandering by offering pleasant diversions, structured activities, food, conversations, and books. The resident prefers the Cardinal baseball, Ted Williams, Iowa wrestling, Dan Gable, Willie Nelson, Johnny Cash, and horses. (Revised again on 7/17/20.) - identify patterns of wondering as appears lonely at times and intervene as appropriate. Have conversations as allowed and as able. (Revised again on 7/17/20). Resident #2 had Investigation Reports completed for having altercations with other residents that were completed on 3/6/20, 3/25/20, 4/4/20, 4/20/20, 6/11/20, 7/3/20 and 7/16/20, and altercations on 3/17/20, 4/16/20, and 4/20/20 not reported. The Incidents for Resident #2 on 3/17, 3/25, 4/4, 6/11, 7/3, and 7/16/20 involved altercations with the same resident, Resident #4. The facility's Incident/Investigation Reports with other residents were shown as followed: - 3/9/20- reported an investigation hitting and punching between 2 residents. - 3/17/20- records showed an incident witnessed, not written up, investigated, or reported. Resident #2 pushed a resident to the floor. - 3/25/20- reported an investigation with a resident on the floor in front of Resident #2's room and telling that resident to stay out. - 4/4/20-reported an investigation with a resident on the floor in front of Resident #2's room and yelling at that resident. - 4/16/20-not reported but witnessed for inappropriateness regarding Resident #2's exposed genital area. - 4/20/20- not reported for a physical encounter witnessed with Resident #2 hands to another's residents throat. - 6/11/20-reported an investigation with Resident #2 pushing, attempting to or/slapped another resident , leaving a red mark. - 7/3/20- not reported, as determined a fall by a resident in Resident #2's room, as Resident #2 stood by. - 7/16/20- reported an investigation witnessed where Resident #2 pushed another resident to the floor, causing a black eye, abrasions to the shoulder and neck. That fallen resident favored their arm while walking the next day an x-ray had been ordered. Observation on 8/3/20 at 11:00 a.m., revealed Resident #4 ambulating in the front hall just past Resident #2's room holding a blanket as it dragged around one of their feet. Resident #2 ambulated from the opposite way, heading to room [ROOM NUMBER]. Resident touched Resident #4's left shoulder with one hand as they passed and both residents kept going. A staff person from the far end of the front hall, going into a supply/bath room also observed the 2 residents in the hall and came down to adjust Resident #4's blanket, away from their foot. Observation on 8/3/20 at 10:30 a.m., revealed the Nurses Station had windows all the way around on the top half of the oblong area. The front and some of the left side windows had decorations and papers covering most of the lower window areas (approximately 1/3 covered up from bottom toward the top.) While standing inside the station there were areas where one stood, one could not observe room [ROOM NUMBER]. The front windows were difficult to see through to the front hall (where the 2 residents passed each other) and to visualize the entrance due to decorations and paper notices posted. During an interview on 7/29/20 at 3:30 p.m., Staff D, Licensed Practical Nurse (LPN), MDS Coordinator and designee Social Worker stated the Charge Nurse writes up the incident report,

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) notifies the DON and the DON follows the report. Staff D reported the protocol for resident to resident altercations are to separate, make sure of safety for all residents, assess the residents involved and notify the DON, if unavailable, notify the Acting Administrator immediately. During an interview on 8/3/20 at 11:40 a.m., Staff G, RN, stated every 15 minute checks for Resident #2 are okay during the night but felt they are not enough during the day. Staff G remarked it is very difficult to do her job plus keep constant eye contact on the resident. Staff G remarked just this morning doing med pass she asked the housekeeper (not an CNA) to watch the resident for awhile. During an interview on 8/3/20 at 1:30 p.m., with Staff G (RN) and Staff D (LPN), Staff G stated she had just found out that she was supposed to do constant eye to eye contact with Resident #2. Staff D stated no one had really told the charge nurses they were to be on constant eye contact. Staff D stated her understanding was if the resident was in their own room, then only 15 minute checks were to be done during that time. Staff D noted they have no idea when the resident leaves the room and he/she can move quite fast at times. They felt the care plan did not exactly say eye contact and appeared vague and confusing. Both nurse's felt it was nearly impossible to keep eye to eye contact with the resident at all times. They both stated it would be a better approach to have an assigned extra person to do 1 to 1 supervision with the resident. Staff D stated there were 3 residents on the unit that require 2 staff assistance with all their cares. She stated having 2 CNA's and 1 Nurse on duty, leaves 1 staff person to monitor all the other residents and it can get busy. They also commented there have been no group huddles with staff members to help come up with other ideas for interventions. Staff D stated the facility had not tried a door alarm, or stop signs that may deter Resident #4, or tried changing one of the residents rooms to a different location on the unit. During an interview on 8/3/20 at 2:00 p.m., the Acting Administrator stated after the 3/25/20 altercation between Resident #2 and Resident #4 they placed Resident #2 on every 15 minute checks until the latest episode (7/16/20). She stated now the charge nurses are to keep an eye on Resident #2 at all times. She stated if the charge nurse has other tasks to attend to, they assign another staff person the watch the resident. She did not remember any other interventions and did not remember any staff huddles to get everyone's ideas for other interventions for Resident #2. She reported her and the DON discussed a door alarm or a stop sign but did not know if that would be appropriate. The Acting Administrator stated Resident #2 has had medication changes and also stated it is hard on the residents to change rooms. During an interview on 8/4/20 at 12:30 p.m., Staff I, Life Events and part time housekeeper, reported she usually does activities from 1 p.m. to 5 p.m. during the day and will do housekeeping in the mornings when other housekeeping staff are gone. During an interview on 8/4/20 at 1:02 p.m., Staff H, CNA, reported there were no staff huddles to see what interventions could help with Resident #2. She remarked it is difficult to do 1 to 1 supervision with Resident #2 without extra staff help to do 1 on 1 observations directly. During an interview on 8/4/20 at 3:17 p.m., Staff B, Licensed Practical Nurse (LPN), stated she felt nothing had really been done for different interventions for Resident #2's behaviors. She stated it seemed like all they did was change the resident's medications and continue the 15 minute checks. Staff B stated they are to keep an eye on him 24/7. She stated the resident's room is not in the best location and they never know when he/she leaves their room. Staff B stated the protocol for altercations/incidents is they are to be written up in an incident report, gather statements as needed, and hand over to the DON who makes the calls and follows through with the investigations. During an interview on 8/5/20 at 11:45 a.m., the Acting Administrator stated she relied on the DON and the MDS Coordinator for interventions for resident concerns. She stated after this last incident on 7/16/20 she insisted on stronger interventions and not just 15 minute checks. She found out the MDS Coordinator had been in contact with the Veteran's (VA) Hospital in Iowa City. The DON received a call back and the VA would refer the resident to the Behavioral Recovery Outreach Program (BRO) to help treat behaviors with interventions which started 7/17/20. The Acting Administrator stated she expected the DON to follow up with all incidents by implementing interventions, communicate to staff, call the families. During an interview on 8/5/20 at 1:20 a.m., the DON, after reviewing the incidents, stated they need to be better with engaging residents and look for other ideas. The DON also acknowledged not holding huddles with staff to brainstorm for ideas, especially for Resident #2. During an interview on 8/10/20 at 11:11 a.m., Staff B, LPN, stated the DON had asked her if she thought Resident #2 pushed Resident #4 on the 4/4/20 incident. She stated she had replied she thought so, and asked why else would Resident #4 be on the floor with Resident #2 yelling over the resident, as Resident #4 doesn't fall down on his/her own. The facility's Resident to Resident Prevention, Identification, Investigation, and Reporting Policy dated 7/30/17 stated the Purpose is all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The Policy also defined Abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The Policy also defined Resident to Resident physical contact that occurs, which includes but is not limited to where residents are hit, slapped, pinched or kicked and result in physical harm, pain, or mental anguish is considered resident to resident abuse. The facility will presume that instances of abuse cause physical harm, or pain or mental anguish in residents with cognitive and/or physical impairments which may result in a resident unable to communicate physical harm, pain or mental anguish, in the absence of evidence to the contrary.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation. staff interview, and record review the facility failed to provide adequate nursing supervision to protect residents from injury by another resident for 2 out 4 residents reviewed. (Resident #2, #4). involving several altercations between Resident #2 and #4. The facility identified a census of 16 residents in the Dementia Unit. Findings include: 1. Resident #2's Minimum Data Set (MDS) quarterly assessment dated [DATE] documented the resident with a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. The MDS documented the resident was independent with ambulation, had inattention and disorganized thinking. The resident's behaviors included physical, verbal aggression directed at others and had delusions and hallucinations. The MDS listed [DIAGNOSES REDACTED]. Resident #2's Care plan dated 3/2/20 identified the a behavior problem related to dementia. The following interventions for this concern included: - Revised on 3/9/20: assist the resident to develop more appropriate methods of coping and interacting with staff and peers and encourage the resident to express feelings appropriately. - intervene as necessary to protect the rights and safety of others. - approach/speak in a calm manner, divert attention and remove the resident from situation and take to an alternate location as needed. The resident can be very territorial and protective of what belongs to him/her. - Revised on 6/12/20: the residents second spouse looks similar to Resident #4 (bad marriage) and this may be a trigger for the resident. - Revised on 3/27/20: minimize potential for the resident's disruptive behaviors (yelling/screaming) by offering to talk about baseball (Cardinals), Willie Nelson, or Iowa Wrestling which diverts attention. - Revised on 3/9/20: provide a program of activities that is of interest and accommodates the residents status such as the Cardinals, Ted Williams, Iowa wrestling, Dan Gable, Willie Nelson, Johnny Cash and horses. - Revised on 7/17/20: the resident is to be monitored by the nurse and when the nurse is not available she is to assign a staff member to monitor in her absence and continue to document on 15 minute check sheets, redirect the resident when approaching others personal space (related to territorial behaviors and post traumati[DIAGNOSES REDACTED] disease). The Care Plan, with a revision date of 4/16/20, identified a problem as being at risk for elopement, wandering aimlessly, significantly intrudes on privacy or activities. Interventions for this concern included: - distract the resident from wandering by offering pleasant diversions, structured activities, food, conversations, and books. The resident prefers the Cardinal baseball, Ted Williams, Iowa wrestling, Dan Gable, Willie Nelson, Johnny Cash, and horses. (And revised again on 7/17/20.) - identify patterns of wondering as appears lonely at times and intervene as appropriate. Have conversations as allowed and as able. (Revised again on 7/17/20). Resident #2 had Investigation Reports completed for having altercations with other residents that were completed on 3/6/20, 3/25/20, 4/4/20, 4/20/20, 6/11/20, 7/3/20 and 7/16/20, and altercations on 3/17/20, 4/16/20, and 4/20/20 not reported. The Incidents for Resident #2 on 3/17, 3/25, 4/4, 6/11, 7/3, and 7/16/20 involved altercations with the same resident, Resident #4. Resident #4's MDS quarterly assessment dated [DATE] documented the resident with a BIMS score of 2 which indicated severe cognitive impairment. The MDS documented disorganized thinking, independence with ambulation, gait steady at all times and no impairment with range of motion The MDS also showed the resident had [DIAGNOSES REDACTED]. The facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165135	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STRAWBERRY POINT LUTHERAN HOME	**313 ELKADER STREET STRAWBERRY POINT, IA 52076**

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) Incident/Investigation Reports between the 2 residents were shown as followed: - 3/17/20- an incident witnessed, not written up, investigated, or reported had occurred between the 2 residents. Resident #2 pushed Resident #4 into the nursing station by Resident #2's room, where Resident #4 fell to the floor. There were no injuries. - 3/25/20- Resident #4 found on the floor in front of Resident # 2's room. Resident #2 yelling at Resident #4 to stay out of the room. - 4/4/20- Resident #4 found on the floor in front of Resident #2's room and yelling. - 6/11/20-Resident #2 pushing and attempting to slap Resident #4 with the fingertips, leaving a red mark. A written statement by a staff person documented Resident #2 slapped Resident #4 - 7/3/20- Resident #4 found on the floor, while Resident #2 stood to the left side. This incident had been determined as a regular fall and not an altercation between the 2 residents, as there were no witness's to observe the fall. The conclusion by the Director of Nursing (DON) determined Resident #4 appeared to have fallen to the floor, hitting the wall and the open door. Resident #4 had a red area to lower left cheek and a light scratch down left neck and a small red area on the right arm. The Report documented that Resident #2 had not appeared to be upset at that time. - 7/16/20- A staff member witnessed Resident #2 push Resident #4 to the floor. A Certified Nursing Aide (CNA) witnessed Resident #2 push Resident #4 onto the floor in front of the Nursing Station. The Staff person heard Resident #4 state Resident #2 tried to kill him/her. Resident #4 received a 3 centimeter (cm.) by 2 cm. raised area with a few scattered marks under the left eye, a 4 cm. by 3 cm. abrasion on the left shoulder and a 2 cm. by 2 cm. abrasion on the left knee. On 7/17/20 the DON noted on the report Resident #4 had a black left eye and into using the left arm. The ARNP (Advanced Registered Nurse Practitioner) called and ordered portable X-rays to be done. Observation on 8/3/20 at 11:00 a.m., revealed Resident #4 ambulating in the hall just past Resident #2's room dragging a blanket. Resident #2 ambulated from the opposite way heading to room [ROOM NUMBER]. Resident #2 touched Resident #4's left shoulder as they passed and both resident's kept going. A staff person from the far end of the front hall, going into a supply/bath room also observed the 2 residents in the hall and came down to adjust Resident #4's blanket, away from the feet. Observation on 8/3/20 at 10:30 a.m., revealed the Nurses Station had windows all the way around on the top half of the oblong area. The front and some of the left side windows had decorations and papers covering most of the lower window areas (approximately 1/3 covered up from bottom toward the top.) While standing inside the area, there were areas where one could not observe room [ROOM NUMBER]. The front windows were difficult to see through to the front hall (where the 2 residents passed each other) and entrance due to decorations and paper notices posted. During an interview on 7/29/20 at 3:30 p.m., Staff D, Licensed Practical Nurse (LPN), MDS Coordinator and Social Worker designee, stated the Charge Nurse writes up the incident report, notifies the DON and the DON follows the report. Staff D reported the protocol for resident to resident altercations are to separate, make sure of safety for all residents, assess the residents involved and notify the DON, if unavailable, notify the Acting Administrator immediately. They will investigate the incident which occurred. Staff D remarked about another incident on 3/17/20 as Staff A informed her of what altercation she had seen between Resident #2 and #4. Staff D did not know if this had been reported or not. Staff D also expressed concern regarding the incident between the same residents on 7/16/20, as she had thought Resident #4 should have been sent to the hospital. She noted the Advanced Registered Nurse Practitioner (ARNP) had wanted to send Resident #4 to the hospital. During an interview on 8/3/20 at 10:47 a.m., the resident's family member stated the facility called about incidents happening with their family member with the same resident, and stated it keeps happening. The family member stated the other resident needed to go somewhere else. The family member acknowledged the resident did not have to go to the hospital as the staff could monitor the resident at the facility. During an interview on 8/3/20 at 11:40 a.m., Staff G, RN, reported every 15 minute checks for Resident #2 are okay during the night but felt they are not enough during the day. Staff G remarked it is very difficult to do her job plus keep constant eye contact on the resident. During an interview on 8/3/20 at 1:30 P.M.,. with Staff G and Staff D,LPN, Staff G stated she had just found out that she was supposed to do constant eye to eye contact with Resident #2. Staff D stated no one had told the charge nurses they were to be on constant eye contact. Her understanding was if the resident was in their room, then only 15 minute checks were to be done during that time. Staff D noted they have no idea when the resident leaves the room and he/she can move quite fast at times. They felt the care plan did not exactly say eye contact and appeared vague and confusing. Both nurses felt it was nearly impossible to keep eye to eye contact with the resident at all times. They stated it would be a better approach to have an assigned extra person to do 1 to 1 supervision with the resident. Staff D remarked there were 3 residents in the unit requiring 2 staff assistance with all their cares. She noted having 2 CAN's and 1 Nurse on duty, leaves 1 staff person to monitor all the other residents and it can get busy. They also commented there have been no group huddles with staff members to help come up with other ideas for interventions. Staff D stated the facility has not tried a door alarm, or any stop signs, that may deter Resident #4, or try changing one of the residents rooms to a different location in the unit. During an interview on 8/3/20 at 2:00 p.m., the Acting Administrator reported after the 3/25/20 altercation between Resident #2 and Resident #4 they placed Resident #2 on every 15 minute checks until this latest episode (7/16/20) and now it is an eye on Resident #2 at all times by the charge nurse. She did not remember any other interventions and did not remember any staff huddles to get everyone's ideas for other interventions for Resident #2. She stated she and the DON discussed a door alarm or a stop sign but did not know if that would be appropriate. The Acting Administrator noted Resident #2 has had medication changes and also noted it is hard on the residents to change rooms. During an interview on 8/4/20 at 12:30 p.m., Staff I, Life Events and part time housekeeper, reported she usually does activities from 1 p.m. to 5 p.m. during the day and will do housekeeping in the mornings when other housekeeping staff are gone. During an interview on 8/4/20 at 1:02 p.m., Staff H, CNA, reported there were no staff huddles to see what interventions could help with Resident #2. She remarked it is difficult to do 1 to 1 supervision with Resident #2 without extra staff help. During an interview on 8/4/20 at 3:17 p.m., Staff B, Licensed Practical Nurse (LPN), stated feeling nothing had really been done for different interventions for Resident #2's behaviors. She stated it seemed like all they did was change the resident's medications and continue the 15 minute checks. She stated they are now to keep an eye on him 24/7. 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