

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/15/2025
NAME OF PROVIDER OR SUPPLIER Salem Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2027 College Avenue Elk Horn, IA 51531	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, resident interviews, family interviews, staff interviews and policy review the facility failed to provide dignity and respect when a nurse yelled at a resident about being outside of the facility and smoking on the sidewalk to 1 of 3 residents reviewed (Resident #1). The facility reported a census of 52 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #1 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. On 12/11/25 at 10:05 AM Resident #1's daughter explained staff were not allowed to take her mother outside to smoke if they were employed at the facility. Resident #1's daughter stated there was a situation where an employee took her mother outside to smoke and a nurse went outside and yelled at the nurse and the CNA. Resident #1 daughter said her mother does not need permission to smoke on the sidewalk. Resident #1's daughter explained that the sidewalk was not owned by the facility and was not part of the facility's property. Resident #1's daughter stated her mother can walk short distances on her own but will require one staff to walk her and one staff to push the wheelchair to follow. Resident #1's daughter stated Staff A, Certified Nurse Assistant (CNA) was the CNA that was outside with her mother during the incident. On 12/11/25 at 2:12 PM Resident #1 stated had been at the facility since 7/24/25. Resident #1 stated some staff treat her good and some treat her bad. Resident #1 stated she goes outside and smokes with her daughter. Resident #1 stated she was told that she could not go out to smoke. Resident #1 said the staff are not allowed to push her outside. Resident #1 explained the staff are not allowed to take her outside, not when they are on break or when they are not working. Resident #1 said there was staff that got in trouble for taking her outside to smoke. Resident #1 said Staff A and Staff B, CNA got written up. Resident #1 explained she could smoke on the side walk out front. Resident #1 said the Administrator said that he does not like a lot of people smoking on the sidewalk. Resident #1 stated when Staff B and Staff A took her out to smoke, Staff C, Licensed Practical Nurse yelled at all of them. Resident #1 said Staff C was yelling at her out the door that she could not smoke out there. Resident #1 said she was upset about the incident but she was not scared of the nurse. Resident #1 said she felt bad because she was the reason the staff were yelled at. Resident #1 explained she felt Staff C did not give her dignity or respect when she yelled at her. Resident #1 stated she had very little interaction with Staff C prior to the incident or after the incident. On 12/11/25 at 2:58 PM Staff C, LPN stated if she heard anyone yelling at a resident she would be on them. Staff C explained she was the enforcer at the facility. Staff C stated she tried not to talk down to a resident. Staff C said she had never yelled at a resident but she might have been stern at times. Staff C stated 2 of the CNAs took a resident outside to smoke and she was loud when she went outside to talk to them but they had to hear her. Staff C stated the 3 of them were on the facility's sidewalk not the public sidewalk. Staff C stated she was more upset with the CNAs than the resident. Staff C stated she told the resident that the CNAs are not to be taking her out to smoke. Staff C stated she told the resident only her family could take the resident outside. Staff C explained the resident told her that the Administrator told her that she could smoke on the public sidewalk. Staff C stated the CNAs was Staff A and she did not remember the other CNAs name. Staff C said the Director of Nursing (DON) after it happened. Staff C explained the facility owned the whole sidewalk in front of the facility and she knew that because the facility used to load and unload right on the corner. On 12/15/25 at 10:33 AM Staff A, CNA stated an incident occurred with Resident #1. Staff A explained Resident #1 had asked to be taken outside to smoke. Staff A stated she told Resident #1 over and over again that she could not. Staff A said Resident #1 then started crying and was told the other CNA was going to take her outside so Staff A took Resident #1 outside. Staff A explained that Staff C came outside and started yelling at her, Staff B and Resident #1. Staff A stated Resident #1 seemed upset that Staff C seemed angry when yelling at them and Resident #1. Staff A stated she was written up for taking Resident #1 outside to smoke and the write up was ripped up a week later. Staff A stated Staff D, Staff Development Coordinator destroyed the write up. Staff A stated she was told the staff are not supposed to take Resident #1 outside to smoke. Staff A stated Staff D stated there was no policy about staff taking Resident #1 outside to smoke. Staff A stated Staff D told her the staff just can't smoke with Resident #1. Staff A explained Resident #1 was and apologized for getting Staff A in trouble. Staff A stated there was no reason for Staff C to yell at the Resident #1. Staff A stated she did not report the incident to the administration. Staff A explained that Staff C did call the DON after the incident occurred. On 12/15/25 at 11:44 AM Staff B, CNA stated the Administrator and the DON</p>		