STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy and procedure review, resident and staff interviews the facility failed to treat a resident with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for 1 out of 4 residents reviewed. (Resident #4). The facility identified a census of 46 residents.Findings include:Resident #4's Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 for which indicated intact cognitive decisions, is able to be understood and understands others, and no behaviors or mood present. The MDS addressed the residents as dependent on staff for all activities of daily living (toileting hygiene, upper and lower body dressing, and personal hygiene) dependent on transfers and once in an electric wheelchair independent in the facility. The MDS included diagnosis of heart failure, hypertension (a condition where blood force against artery wall is consistently too high forcing the heart to work harder), diabetes mellitus, hemiplegia (paralysis affecting only one side of the body, caused by brain or spinal cord damage), anxiety and depression.The Care Plan with an initiated date 3/24/26, explained that the resident has a psychosocial well-being deficit of past trauma identified per trauma assessment. Interventions include, discuss residents' feelings relative to sadness, crying, isolation, assist/encourage/support resident to set realistic goals, provide assistance/supervision/support with identification of potential solutions to present problems and provide opportunities for resident and family to participate in care, assist resident to develop more appropriate methods of coping.On 5/12/26 at 4:44 PM, observed Resident #4 sitting in an electric wheelchair in her room. Dressed appropriately in slacks, and a long sleeve shirt. Resident #4 stated that Staff A, Certified Nursing Assistant (CNA), is rude, mean and disrespectful. Resident #4 went on to explain that Staff A, CNA, will throw Resident #4 call light at her and say that Resident #4 does not need to be changed and can wait. Resident #4 did not say anything to the facility Administrator or Director of Nursing due to repercussions from Staff A, CNA. Resident #4 stated that Staff A, CNA, does this type of behavior when they are alone in Resident #4's room.The Progress Notes dated 5/12/26 at 5:45 PM, late entry, documented, Administrator and Director of Nursing (DON) met with the resident on 5/12/26 at approximately 5:45 PM to discuss resident care concerns. Resident most recent BIMS score is 15. Physician notified of resident care concern. The Progress Notes dated 5/13/26 at 9:53 AM, documented Social Worker (SW) had conversation with Resident #4 regarding behaviors at night and what is triggering them. Resident #4 stated if the staff would put me to bed at a decent time. SW asked what time she is put to bed and she said 8:00-8:30 PM. SW asked what time she wanted to go to bed and Resident #4 stated 7:30 PM. SW asked if she is put to bed at 7:30 PM the behaviors would cease? Resident #4 said yes, that all she is asking. SW forwarded the information to the nurse managers.The 5 day report dated 5/16/26, documented that the Administrator and Interim DON were able to meet with Resident #4 after supper at 5:45 PM. Resident #4 stated that Staff A, CNA, yells at Resident #4, threw the call light one time, and is mean to Resident #4. Resident #4 went into a few other incidents with Staff A, CNA, not returning the water pitcher, and changes the brief too fast and does not do a good enough job. Resident #4 again, said that Staff A, CNA, is mean and (continued on next page)

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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 does not trust Staff A, CNA. When asked why, Resident #4 did not mention this any other time, Resident #4 stated that she was afraid of backlash from Staff A, CNA. Resident #4 said that a scratch on the stomach was caused by a call light that was thrown at her, yet the DON looked at it and said that it was a long scratch that was scabbed over and would be almost impossible to get from a small call button. We distributed our policies on Abuse and Neglect to educate all staff and required them to sign that they understand it.On 5/19/26 at 1:45 PM, Resident #4 stated that since Staff A, CNA, has not been in the building, staff have been treating her with kindness, dignity and respect. On 5/20/26 at 1:22 PM, the facility Administrator confirmed, verified and acknowledged that the expectation of the staff is to treat all residents with dignity and respect at all times and to follow the facility policy for Resident Dignity. The Resident Dignity Policy dated 12/18/25, is that the policy is to promote care for residents in a manner and in an environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality. The purpose is to maintain the dignity of all residents, promote, encourage, support and enhance the residents self-esteem and to assist with respecting and ensuring resident rights.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review, the facility failed to notify the physician of a pain patch that was not activated for 48 hours for 1 of 1 resident reviewed (Residents #1). The facility reported a census of 46 residents.Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 7 for which indicated severe cognitive decisions, is able to be understood and understands others, with hallucinations and delusions present along with resisting of cares. The MDS addressed the resident as substantial to maximal assistance on staff for all activities of daily living (toileting, oral and personal hygiene, and upper and lower body dressing) and pain described as frequent with intensity of a 2 out of a numeric scale of 1-10, and poor prognosis with an opioid used within the last 7 days. The MDS included diagnosis of hypertension (a condition where blood force against the artery wall is consistently too high forcing the heart to work harder), diabetes mellitus, neurogenic bladder (a condition where nerve damage disrupts the communication between the brain and the bladder, resulting in a loss of bladder control), Non-Alzheimer's dementia, arthritis, anxiety and depression.The Plan of Care with a revision dated 4/5/26, had a focus area that addresses the resident has chronic pain and is at risk for opioid overdose/complications related to opioid use-Fentanyl (a powerful synthetic opioid) 75 micrograms per hour. Interventions include, notify health care provider if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain, provide resident and family with information about pain and options available for pain management and discuss and record preferences.The Progress Notes dated 4/3/26 at 4:16 PM, fentanyl transdermal patch 75 micrograms per hour apply patch one time a day every 2 days for pain.The Medication Error Report Form with date of error 4/1/26, revealed fentanyl 75 microgram patch, change every two days and that the resident response related to error was an increase in as needed morphine (a powerful, naturally occurring opioid analgesic derived from the opium poppy, primarily used to treat moderate to severe acute or chronic pain) usage.The review of the Progress Notes lacked documentation of the medication error and notification of the physician. On 5/12/26 at 5:40 PM, Staff D, Registered Nurse (RN), confirmed and verified that the fentanyl patch that was found on 4/3/26 was not activated and that Staff D, failed to remove the plastic backing from the patch prior to applying to Resident #1.On 5/13/26 at 1:33 PM, Staff C, Licensed Practical Nurse (LPN), confirmed and verifed that the fentanyl patch still had the plastic backing on when placed in the narcotic box in the locked medication room.On 5/19/26 at 12:00 PM, Staff E, RN, confirmed and verified that the plastic backing was still on the fentanyl patch when it was removed from Resident #1 and was placed in the narcotic box in the locked medication room.On 5/22/26 at 9:08 AM, Staff C, LPN, confirmed and verified that the primary care physician was not notified of the medication error per facility policy and procedure of the fentanyl patch not being activated on 4/3/26.On 5/22/26 at 11:22 AM, the Administrator, Assistant Director of Nursing (ADON) and the Director of Nursing (DON) acknowledged that the clinical record lacked documentation of the medication error and that the staff failed to notify the primary care physician of the medication error and it is expected that staff follow the facility policy with notifying the physician.Review of the Notification of Change with a revision dated 12/12/25, a facility must immediately inform the resident physician and notify, consistent with his or her authority, the resident representative(s) when there is: a need to alter treatment significantly-a need to discontinue or change an existing form of treatment or to commence a new form of treatment.Review of the Medication Errors with a revision dated 3/2/26, the purpose is to provide guidance in documenting and auditing medication errors. When a medication error occurs, it will be reported promptly to the attending physician, resident and or responsible party and documented.

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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 clinical record review, staff interview and review of policy and procedures, the facility failed to ensure all alleged violations of abuse involving mistreatment, neglect, and injuries of unknown source were reported to the Department of Inspection and Appeals and Licensing (DIAL) within 2 hours for 2 of 3 resident reviewed. (Resident #2 and Resident #9). The facility reported a census of 46 residents.Findings include:1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 1, indicating severely impaired cognitive decisions. Resident #2 could understand others and others usually understood them. They have no behavior, mood or delirium. Resident #2 required partial to moderate assistance with all aspects of daily living (dressing, personal hygiene, transfers, oral hygiene and positioning) and no falls documented and a use of an anti-coagulant (medications that prevent blood from clotting or stop existing clots from getting larger) medication used in the last 7 days. The MDS included diagnoses of Non-Alzheimer's Dementia, muscle weakness, hypertension, (a chronic condition where blood force against artery walls is consistently too high), and repeated falls.The Care Plan Focus area revised on 3/17/26, identified that the resident is on an anti-coagulant therapy related to history of thrombosis (the formation of a blood clot inside a blood vessel, which obstructs the normal flow of blood) and emboli (detached, traveling masses,such as blood clots, air bubbles, or tumor cells, that move through the bloodstream) and has potential for skin impairment related to advancing dementia and needing more assistance with ambulation. Interventions include to identify potential causative factors and eliminate/resolve where possible. The Skin Observation tool dated 4/6/26 at 10:18 AM, documented right wrist has purple bruise measuring 2 centimeters by 1.5 centimeters. No swelling noted. No complaints of pain.On 5/20/26 at 2:02 PM, observed Resident #2 sitting in a recliner in her room, no noted purple bruise on the right wrist. Resident #2 was not able to recall an incident about a bruise to the right wrist.The clinical record lacked documentation of the investigation of the injury of unknown origin.On 5/22/26 at 12:02 PM, the facility Director of Nursing confirmed and verified that the clinical record lacked documentation of the incident with Resident #2 and that the expectation of the staff are to follow the facility procedure/policy for injuries of unknown origin. On 5/22/26 at 12:12 PM, the facility Administrator acknowledged that all staff are expected to report any allegations of abuse or injuries of unknown origin immediately and to start an investigation and that the clinical record lacked documentation of an incident report of that DIAL was notified. 2. Resident #9's MDS assessment dated [DATE], identified the resident with short and long term memory impairments with severe decision making abilities. Resident #9 could understand others and others usually understood them. They have behavior such as hallucinations and delusions, and resisting care. Resident #9 required partial to moderate assistance with dressing and supervision for oral, toileting and personal hygiene and independent in facility with ambulation and transfers with no assistive devices used and no falls documented and a use of an anti-coagulant (medications that prevent blood from clotting or stop existing clots from getting larger) medication used in the last 7 days. The MDS included diagnoses of malnutrition, anxiety and schizophrenia.The Plan of Care focus area with a revision dated 3/19/26, documented the resident is on an anticoagulant therapy related to history of pulmonary embolism (a sudden blockage in a lung artery, typically caused by a blood clot that travels from a deep vein in the legs). Interventions include to monitor/document/report bruising or sudden changes in mental status.The Skin Observation tool dated 4/13/26 at 6:01 PM, documented brown bruising noted to under left eye. Resident complains of pain to the area. No swelling noted upon inspection. Resident refused to allow staff to touch the area.The Progress Notes dated 4/13/26 at 6:04 PM, documented found brown bruising noted to underleft eye. Resident complains of pain. No swelling noted upon inspection and resident refused staff to touch the area.On 5/19/26 at 2:15 PM, observed Resident #9 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sitting in the dining area in a recliner, dressed appropriately. Resident was not able to recall or have any recollection of an incident that resulted in the left eye being bruised.The clinical record lacked documentation of the investigation of the injury of unknown origin.On 5/22/26 at 12:02 PM, the facility Director of Nursing confirmed and verified that the clinical record lacked documentation of the incident with Resident #9 and that the expectation of the staff are to follow the facility procedure/policy for injuries of unknown origin. On 5/22/26 at 12:122 PM, the facility Administrator acknowledged that all staff are expected to report any allegations of abuse or injuries of unknown origin immediately and to start an investigation and that the clinical record lacked documentation of an incident report of which DIAL was notified. Review of the Abuse and Neglect policy revised 4/7/25, is to ensure that employees are knowledgeable regarding the reporting and investigative process of abuse, and neglect allegations. To ensure that all identified events of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported and investigated. Alleged or suspected violations involving mistreatment or injuries of unknown origin will be reported immediately to the administrator. In the absence of the administrator, the following individuals have the administrative authority of the administrator for purposes of immediately reporting of alleged violations: the director of nursing services or the supervisor or social services.

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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 clinical record review, policy review, and staff interviews, the facility failed to investigate injuries of unknown injury for 2 of 3 residents reviewed (Resident #2 and Resident #9). Resident #2 had a bruise on the right wrist and Resident #9 had a bruise underneath the left eye. The facility reported a census of 46 residents.Finding include:1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 1, indicating severely impaired cognitive decisions. Resident #2 could understand others and others usually understood them. They have no behavior, mood or delirium. Resident #2 required partial to moderate assistance with all aspects of daily living (dressing, personal hygiene, transfers, oral hygiene and positioning) and no falls documented and a use of an anti-coagulant (medications that prevent blood from clotting or stop existing clots from getting larger) medication used in the last 7 days. The MDS included diagnoses of Non-Alzheimer's Dementia, muscle weakness, hypertension, (a chronic condition where blood force against artery walls is consistently too high), and repeated falls.The Care Plan Focus area revised on 3/17/26, identified that the resident is on an anti-coagulant therapy related to history of thrombosis (the formation of a blood clot inside a blood vessel, which obstructs the normal flow of blood) and emboli (detached, traveling masses,such as blood clots, air bubbles, or tumor cells, that move through the bloodstream) and has potential for skin impairment related to advancing dementia and needing more assistance with ambulation. Interventions include to identify potential causative factors and eliminate/resolve where possible. The Skin Observation tool dated 4/6/26 at 10:18 AM, documented right wrist has purple bruise measuring 2 centimeters by 1.5 centimeters. No swelling noted. No complaints of pain.On 5/20/26 at 2:02 PM, observed Resident #2 sitting in a recliner in her room, no noted purple bruise on the right wrist. Resident #2 was not able to recall an incident about a bruise to the right wrist.The clinical record lacked documentation of the right wrist bruise.On 5/22/26 at 12:02 PM, the facility Director of Nursing confirmed and verified that the clinical record lacked documentation of the incident with Resident #2 and that the expectation of the staff are to follow the facility procedure/policy for injuries of unknown origin. On 5/22/26 at 12:122 PM, the facility Administrator acknowledged that all staff are expected to report any allegations of abuse or injuries of unknown origin immediately and to start an investigation and that the clinical record lacked documentation of an incident report of that DIAL was notified. 2. Resident #9's MDS assessment dated [DATE], identified the resident with short and long term memory impairments with severe decision making abilities. Resident #9 could understand others and others usually understood them. They have behavior such as hallucinations and delusions, and resisting care. Resident #9 required partial to moderate assistance with dressing and supervision for oral, toileting and personal hygiene and independent in facility with ambulation and transfers with no assistive devices used and no falls documented and a use of an anti-coagulant (medications that prevent blood from clotting or stop existing clots from getting larger) medication used in the last 7 days. The MDS included diagnoses of malnutrition, anxiety and schizophrenia.The Plan of Care focus area with a revision dated 3/19/26, documented the resident is on an anticoagulant therapy related to history of pulmonary embolism (a sudden blockage in a lung artery, typically caused by a blood clot that travels from a deep vein in the legs). Interventions include to monitor/document/report bruising or sudden changes in mental status.The Skin Observation tool dated 4/13/26 at 6:01 PM, documented brown bruising noted to under left eye. Resident complains of pain to the area. No swelling noted upon inspection. Resident refused to allow staff to touch the area.The Progress Notes dated 4/13/26 at 6:04 PM, documented found brown bruising noted to underleft eye. Resident complains of pain. No swelling noted upon inspection and resident refused staff to touch the area.On 5/19/26 at 2:15 PM, observed Resident #9 sitting in the dining area in a recliner, dressed appropriately. Resident was not able to recall or have any recollection of an incident that resulted in the left eye being bruised.The clinical record lacked (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation of the investigation of the injury of unknown origin.On 5/22/26 at 12:02 PM, the facility Director of Nursing confirmed and verified that the clinical record lacked documentation of the incident with Resident #9 and that the expectation of the staff are to follow the facility procedure/policy for injuries of unknown origin. On 5/22/26 at 12:122 PM, the facility Administrator acknowledged that all staff are expected to report any allegations of abuse or injuries of unknown origin immediately and to start an investigation and that the clinical record lacked documentation of an incident report of which DIAL was notified. On 5/22/26 at 8:33 AM, the Assistant Director of Nursing (ADON), the Director of Nursing (DON) and the Administrator confirmed that no assessment was completed related to the report because they were unaware of Resident #2's and Resident #9's bruises. The ADON, DON and Administrator would expect for investigations to be completed if that was reported to them. The Administrator, DON and ADON revealed they would have investigated the incident if they were notified and this would be for their expectation. Review of policy revised 4/7/25 titled, Abuse and Neglect, documented the purpose is to ensure a complete review by the investigation team to identify events, such as suspicious bruising of residents/clients, occurrences, patterns and trends that may constituent abuse and to determine the direction of the investigation. All alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. If this is an injury of unknown origin, he or she also will attempt to determine the cause of the injury and will ensure that any potential for further abuse is eliminated.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, call light logs and the facility policy/procedure, the facility staff failed to answer resident call lights in a timely manner (no longer than 15 minutes) for 3 of 4 residents reviewed (Resident #4, #5 and Resident #11). The facility identified a census of 46 residents.Findings include: 1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 for which indicated intact cognitive decisions, is able to be understood and understands others, and no behaviors or mood present. The MDS addressed the residents as dependent on staff for all activities of daily living (toileting hygiene, upper and lower body dressing, and personal hygiene) dependent on transfers and once in an electric wheelchair independent in the facility. The MDS included diagnosis of heart failure, hypertension (a condition where blood force against artery wall is consistently too high forcing the heart to work harder), diabetes mellitus, hemiplegia (paralysis affecting only one side of the body, caused by brain or spinal cord damage), anxiety and depression.On 5/13/26 at 9:20 AM, Resident #4 stated that it will take the staff over 15 minutes to answer the call light. Review of the [NAME]-Care Report from 5/16/26-5/17/26, for call light response times, revealed on 5/16/26 at 8:58 PM, Resident #4's call light was on for 34 minutes, 21 seconds, On 5/17/26 at 5:05 PM, was on for 46 minutes and 40 seconds and at 9:13 PM, for 31 minutes and 4 seconds.2. Resident #5 MDS assessment dated [DATE], documented the resident had a BIMS score of 15 for which indicated intact cognitive decisions, is able to be understood and understands others, no behaviors present and no resisting of cares. The MDS addressed the resident as dependent on staff for activities of daily living and once in an electric wheelchair independent in the facility with mobility. The MDS included diagnosis of heart failure, hypertension (a condition where blood force against artery wall is consistently too high forcing the heart to work harder), neurogenic bladder (a condition where nerve damage disrupts the communication between the brain and the bladder, resulting in loss of bladder control) and quadriplegia (the partial or total loss of motor function and sensation in all four limbs(arm and legs) and the torso).On 5/13/26 at 10:44 AM, Resident #5 stated that it will take over 15 minutes to have the call light answered.Review of the [NAME]-Care Report from 5/16/26-5/17/26, for call light response times, revealed on 5/17/26 at 7:57 PM, Resident #5's call light was on for 21 minutes and 53 seconds.3. Resident #11's MDS assessment dated [DATE], documented the resident had a BIMS score of 15 for which indicated intact cognitive decisions, is able to be understood and understands others, no behaviors present and no resisting of cares. The MDS documented the resident is dependent on staff for all activities of daily living and always incontinent of bladder. The MDS included diagnosis of anemia, heart failure, hypertension (a condition where blood force against artery wall is consistently too high forcing the heart to work harder), diabetes mellitus, cerebrovascular accident (blood flow to part of the brain is interrupted or reduced, depriving brain tissue of oxygen and leading to cell death), depression and unsteadiness on feet.On 5/20/26 at 9:00 AM, Resident #11 stated that it will take over 15 minutes to have the call light answered.Review of the [NAME]-Care Report from 5/16/26-5/17/26, for call light response times, revealed on 5/16/26 at 9:08 AM, Resident #5's call light on for 17 minutes and 28 seconds and on 5/17/26 at 7:40 PM, for 31 minutes and 22 seconds.On 5/20/26 at 10:33 AM, the facility Administrator acknowledged that the expectation of staff are to answer the resident call lights in a timely manner, within 15 minutes. On 5/20/26 at 12:56 PM, Staff B, Certified Nursing Assistant (CNA) confirmed and verified that call lights don't get answered within the 15 minutes.On 5/21/26 at 1:11 PM, the facility Director of Nursing acknowledged that the expectation of staff is to answer the resident call lights within 15 minutes.The Call Light Policy revised 7/8/25, stated that the purpose is to ensure residents always have a method of calling for assistance and to promptly answer residents call light. Respond to requests as soon as possible. Turn the call light off and inquire about residents' requests.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility document review, and policy review the facility failed to ensure that a resident was free of significant medication errors for 1 of 4 residents reviewed (Resident #1). On 4/1/26, staff failed to remove the plastic backing off of a Fentanyl (a powerful synthetic opioid) patch for which resulted in Resident #1 not receiving any medication through the patch and experiencing more pain and required an increase in the use of liquid morphine (a powerful, naturally occurring opioid analgesic derived from the opium poppy, primarily used to treat moderate to severe acute or chronic pain) medication until 4/3/26 when a new Fentanyl patch was replaced. The facility reported a census of 46 residents.Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 7 for which indicated severe cognitive decisions, is able to be understood and understands others, with hallucinations and delusions present along with resisting of cares. The MDS addressed the resident as substantial to maximal assistance on staff for all activities of daily living (toileting, oral and personal hygiene, and upper and lower body dressing) and pain described as frequent with intensity of a 2 out of a numeric scale of 1-10, poor prognosis with an opioid used within the last 7 days. The MDS included diagnosis of hypertension (a condition where blood force against the artery wall is consistently too high forcing the heart to work harder), diabetes mellitus, neurogenic bladder (a condition where nerve damage disrupts the communication between the brain and the bladder, resulting in a loss of bladder control), Non-Alzheimer's dementia, arthritis, anxiety and depression.The Plan of Care with a revision dated 4/5/26, documented a focus area that addresses the resident has chronic pain and is at risk for opioid overdose/complications related to opioid use-Fentanyl (a powerful synthetic opioid) 75 micrograms per hour. Interventions include, notify health care provider if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain, provide resident and family with information about pain and options available for pain management and discuss and record preferences.The Progress Notes dated 4/3/26 at 4:16 PM, documented fentanyl transdermal patch 75 micrograms per hour apply patch one time a day every 2 days for pain.The Pain Level Summary dated 5/21/26, showed Resident #1 pain level (on a score of 1-10) on these dates and times for which liquid morphine was administered:4/1/26 at 00:04 AM= score of 44/1/26 at 5:27 AM= score of 44/1/26 at 7:25 AM= score of 24/1/26 at 12:00 PM= score of 34/2/26 at 00:29 AM=score of 54/2/26 at 5:11 AM= score of 54/2/26 at 12:07 PM= score of 54/2/26 at 5:36 PM= score of 74/2/26 at 11:56 PM= score of 54/3/26 at 5:38 AM=score of 5The Medication Error Report Form with date of error 4/1/26, revealed fentanyl 75 microgram patch, change every two days and that the resident response related to error was an increase in as needed morphine (a powerful, naturally occurring opioid analgesic derived from the opium poppy, primarily used to treat moderate to severe acute or chronic pain) usage.Review of the Facility Theft of Narcotic Medication with date of incident 4/3/26, revealed that at 4:16 PM, Staff E, LPN, went to replace a Fentanyl patch on Resident #1, while replacing the patch, Staff E noticed that the membrane on the old patch was not removed from the patch before it was applied to the resident. The patch was dated 4/1/26 and initialed. Since the membrane was not removed, the patch is essentially unused. No messages went out to the Administrator or the Director of Nursing regarding the incident. At 3:20 PM, it was determined that it was a Medication Error, that we need to educate the staff about the disposal of the Fentanyl patch. Statement received on 4/3/26 from Staff E, RN, had to change a Fentanyl patch on Resident #1, when taking off the old patch, it was noticed that the plastic backing was still on the Fentanyl patch that was applied to the resident with a tegaderm (a brand of transparent, sterile film dressings commonly used to act as a second skin), it was dated 4/1/26. After discovering the backing was still on the patch, Staff E, RN, reached out to Staff F, Licensed Practical Nurse (LPN) for guidance. Staff F, LPN informed Staff E, RN, to put the Fentanyl patch in an envelope and place it (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	2027 College Avenue Elk Horn, IA 51531

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F 0760 Level of Harm - Actual harm Residents Affected - Few	underneath the office door of Staff F, LPN. Education was immediately started using our policies and procedures for controlled substances and a test covering the information. Education covered counts, resident rights, medication storage, destruction of medications and not to share keys. All narcotics were counted on 4/7/26 with staff to ensure that nothing was missing. Incident will be taken to monthly quality assurance meeting for further review and recommendations. The narcotic count was never off during the count as the Fentanyl patch should have been discarded after it was taken off.The Medication Administration Record (MAR) for April 2026 documented Morphine Sulfate oral solution 20mg/mg, 0.5ml was given by mouth every 6 hours for pain. The MAR also documented an as needed (PRN) order for Morphine Sulfate oral solution 20mg/ml, 0.5ml by mouth every 1 hour as needed for pain. It was documented as given once on 4/3/26, four times on 4/4/26 and 4 times on 4/5/26. The MAR documented it was not given before this in April 2026. On 5/12/26 at 5:40 PM, Staff D, Registered Nurse (RN), confirmed and verified that the fentanyl patch that was found on 4/3/26 was not activated and that Staff D, failed to remove the plastic backing from the patch prior to applying to Resident #1 on 4/1/26.On 5/13/26 at 1:33 PM, Staff C, LPN, confirmed and verified that the fentanyl patch still had the plastic backing on when placed in the narcotic box in the locked medication room on 4/3/26.On 5/19/26 at 12:00 PM, Staff E, RN, confirmed and verified that the plastic backing was still on the fentanyl patch when it was removed from Resident #1 and was placed in the narcotic box in the locked medication room on 4/3/26.On 5/22/26 at 9:08 AM, Staff C, LPN, confirmed and verified that the primary care physician was not notified of the medication error per facility policy and procedure of the fentanyl patch not being activated on 4/3/26.On 5/22/26 at 11:22 AM, the Administrator, Assistant Director of Nursing (ADON) and the Director of Nursing (DON) acknowledged that the clinical record lacked documentation of the medication error and that the staff failed to notify the primary care physician of the medication error and it is expected that staff follow the facility policy with notifying the physician.Review of the Medication Errors with a revision dated 3/2/26, the purpose is to provide guidance in documenting and auditing medication errors. When a medication error occurs, it will be reported promptly to the attending physician, resident and or responsible party and documented. A significant medication error is one which causes the resident discomfort or jeopardizes his or her health and safety. When the resident receives an amount of medication that is great or less than the amount ordered by the physician. The Omission (medication ordered but not administered) or failure to administer an ordered dose to a resident by the time the next dose is due.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigation review, staff interview and facility policy review, the facility failed to properly destroy Resident #1's narcotic (pain) medication per facility policy/procedure. The facility identified a census of 46 residents.Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 7 for which indicated severe cognitive decisions, is able to be understood and understands others, with hallucinations and delusions present along with resisting of cares. The MDS addressed the resident as substantial to maximal assistance on staff for all activities of daily living (toileting, oral and personal hygiene, and upper and lower body dressing) and pain described as frequent with intensity of a 2 out of a numeric scale of 1-10, poor prognosis with an opioid used within the last 7 days. The MDS included diagnosis of hypertension (a condition where blood force against the artery wall is consistently too high forcing the heart to work harder), diabetes mellitus, neurogenic bladder (a condition where nerve damage disrupts the communication between the brain and the bladder, resulting in a loss of bladder control), Non-Alzheimer's dementia, arthritis, anxiety and depression.The Plan of Care with a revision dated 4/5/26, had a focus area that addresses the resident has chronic pain and is at risk for opioid overdose/complications related to opioid use-Fentanyl (a powerful synthetic opioid) 75 micrograms per hour. Interventions include, notify health care provider if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain, provide resident and family with information about pain and options available for pain management and discuss and record preferences.The Progress Notes dated 4/3/26 at 4:16 PM, documented fentanyl transdermal patch 75 micrograms per hour apply patch one time a day every 2 days for pain.The Medication Error Report Form with date of error 4/1/26, revealed fentanyl 75 microgram patch, change every two days and that the resident response related to error was an increase in as needed morphine (a powerful, naturally occurring opioid analgesic derived from the opium poppy, primarily used to treat moderate to severe acute or chronic pain) usage.Review of the Facility Theft of Narcotic Medication with date of incident 4/3/26, revealed that at 4:16 PM, Staff E, LPN, went to replace a Fentanyl patch on Resident #1, while replacing the patch, Staff E noticed that the membrane on the old patch was not removed from the patch before it was applied to the resident. The patch was dated 4/1/26 and initialed. Since the membrane was not removed, the patch is essentially unused. No messages went out to the Administrator or the Director of Nursing regarding the incident. At 3:20 PM, it was determined that it was a Medication Error, that we need to educate the staff about the disposal of the Fentanyl patch. Statement received on 4/3/26 from Staff E, RN, had to change a Fentanyl patch on Resident #1, when taking off the old patch, it was noticed that the plastic backing was still on the Fentanyl patch that was applied to the resident with a tegaderm (a brand of transparent, sterile film dressings commonly used to act as a second skin), it was dated 4/1/26. After discovering the backing was still on the patch, Staff E, RN, reached out to Staff F, Licensed Practical Nurse (LPN) for guidance. Staff F, LPN informed Staff E, RN, to put the Fentanyl patch in an envelope and place it underneath the office door of Staff F, LPN. Education was immediately started using our policies and procedures for controlled substances and a test covering the information. Education covered counts, resident rights, medication storage, destruction of medications and not to share keys. All narcotics were counted on 4/7/26 with staff to ensure that nothing was missing. Incident will be taken to monthly quality assurance meeting for further review and recommendations. The narcotic count was never off during the count as the Fentanyl patch should have been discarded after it was taken off.On 5/12/26 at 5:45 PM, Staff D, Registered Nurse (RN), and Staff G, RN, confirmed and verified that the expectation of the staff are to follow the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facilities policy/procedure for destroying patches and acknowledged that two staff are to destroy the patch.On 5/12/26 at 5:56 PM, Staff H, LPN, and Staff I, Certified Medication Aide (CMA) both confirmed and verified that the expectation of the staff are to have two nurses or a nurse and medication aide destroy the fentanyl patches in the drug buster or per facility policy/procedure.On 5/20/26 at 10:51 AM, the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) both confirmed and verified that the expectation of the nurses are to follow the policy/procedure for destroying narcotic medications and they acknowledged that the staff failed to follow the policy for destroying Resident #1 fentanyl patch.Review of the Medication:Transdermal Patch Application and Disposal revised 12/8/25, is that the purpose is to administer medication as ordered and to release a continuous and controlled dosage over a specific time period. For patch removal-Fentanyl and other controlled medication patches-disposal should be documented on the Individual Residents Narcotic Record. Narcotic patches should be destroyed by two licensed nurses, or a nurse and pharmacist. Where state guidelines allow a nurse and a trained medication aide may destroy narcotic patches.State-specific regulations regarding medication destruction must be followed. Fentanyl and other controlled medication patches should be folded in half with the sticky sides together and flushed down the toilet or use drug disposal systems such as Drug Buster or Rx Destroyer that minimize accidental exposure and diversion. Sharps containers and trash cans are not compliant. Review of the Medication Disposition revised 8/29/25, the policy is to provide instructions for the accurate disposal of medications. Discontinued medications are to be kept in a secure place in the medication room until these can be returned to the pharmacy or until destroyed according to state regulation. For Controlled substances, two nurses or a nurse and a medication aide must witness the destruction document to ensure accuracy of the count.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to maintain an accurate and complete resident clinical records for residents that had injuries of unknown origin for 2 of 3 residents reviewed (Resident #2 and Resident #9). The facility reported a census of 46 residents. Finding include:1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 1, indicating severely impaired cognitive decisions. Resident #2 could understand others and others usually understood them. They have no behavior, mood or delirium. Resident #2 required partial to moderate assistance with all aspects of daily living (dressing, personal hygiene, transfers, oral hygiene and positioning) and no falls documented and a use of an anti-coagulant (medications that prevent blood from clotting or stop existing clots from getting larger) medication used in the last 7 days. The MDS included diagnoses of Non-Alzheimer's Dementia, muscle weakness, hypertension, (a chronic condition where blood force against artery walls is consistently too high), and repeated falls.The Care Plan Focus area revised on 3/17/26, identified that the resident is on an anti-coagulant therapy related to history of thrombosis (the formation of a blood clot inside a blood vessel, which obstructs the normal flow of blood) and emboli (detached, traveling masses,such as blood clots, air bubbles, or tumor cells, that move through the bloodstream) and has potential for skin impairment related to advancing dementia and needing more assistance with ambulation. Interventions include to identify potential causative factors and eliminate/resolve where possible. The Skin Observation tool dated 4/6/26 at 10:18 AM, documented right wrist has purple bruise measuring 2 centimeters by 1.5 centimeters. No swelling noted. No complaints of pain.On 5/20/26 at 2:02 PM, observed Resident #2 sitting in a recliner in her room, no noted purple bruise on the right wrist. Resident #2 was not able to recall an incident about a bruise to the right wrist.The clinical record lacked documentation of the right wrist bruise.On 5/22/26 at 12:02 PM, the facility Director of Nursing confirmed and verified that the clinical record lacked documentation of the incident with Resident #2 and that the expectation of the staff are to follow the facility procedure/policy for documentation in the clinical record. 2. Resident #9's MDS assessment dated [DATE], identified the resident with short and long term memory impairments with severe decision making abilities. Resident #9 could understand others and others usually understood them. They have behavior such as hallucinations and delusions, and resisting care. Resident #9 required partial to moderate assistance with dressing and supervision for oral, toileting and personal hygiene and independent in facility with ambulation and transfers with no assistive devices used and no falls documented and a use of an anti-coagulant (medications that prevent blood from clotting or stop existing clots from getting larger) medication used in the last 7 days. The MDS included diagnoses of malnutrition, anxiety and schizophrenia.The Plan of Care focus area with a revision dated 3/19/26, documented the resident is on an anticoagulant therapy related to history of pulmonary embolism (a sudden blockage in a lung artery, typically caused by a blood clot that travels from a deep vein in the legs). Interventions include to monitor/document/report bruising or sudden changes in mental status.The Skin Observation tool dated 4/13/26 at 6:01 PM, documented brown bruising noted to under left eye. Resident complains of pain to the area. No swelling noted upon inspection. Resident refused to allow staff to touch the area.The Progress Notes dated 4/13/26 at 6:04 PM, documented found brown bruising noted to underleft eye. Resident complains of pain. No swelling noted upon inspection and resident refused staff to touch the area.On 5/19/26 at 2:15 PM, observed Resident #9 sitting in the dining area in a recliner, dressed appropriately. Resident was not able to recall or have any recollection of an incident that resulted in the left eye being bruised.The clinical record lacked documentation of the investigation of the injury of unknown origin.On 5/22/26 at 12:02 PM, the facility Director of Nursing confirmed and verified that the clinical record lacked documentation of the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident with Resident #9 and that the expectation of the staff are to follow the facility procedure/policy for documentation in the clinical record. Review of policy revised 5/29/25 titled, Health Information Management, stated that the purpose is to provide oversight of health information management services for the organization and assure timely availability of information for the care of patient, residents, and clients. The Scope is chart completion management.