| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165524 | A. Building<br>B. Wing | 08/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethany Lutheran Home | Seven Elliott Street<br>Council Bluffs, IA 51503 |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>37074<br><br>Based on clinical record review, staff interviews and facility policy review the facility failed to follow 1 of 3 resident's (Resident #1) care plan while repositioning her in bed. The facility reported a census of 84 residents.<br><br>Findings include:<br><br>According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 6/11/24 documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented she was frequently incontinent of bowel and had no falls since her admission/entry, reentry or prior assessment. The MDS listed the following diagnosis: spina bifida, seizure disorder, anxiety, opioid use, insomnia, and chronic pain syndrome.<br><br>The Care Plan focus area with an initiation date of 6/13/2023 documented Resident #1 was at risk for decline in her activities of daily living (ADLs) related to her diagnoses of spina bifida and seizures. The care plan documented the following intervention with a revision date of 7/15/2024, the resident required total assistance of two staff to reposition in bed. The resident had bilateral grab bars to assist with repositioning.<br><br>A Progress Note documented on 7/20/24 at 1:21 AM resident had turned on her call light and wanted help from the Certified Nursing Assistant (CNA) to roll to the other side. Resident rolled to right side and was too close to the edge of the bed, air mattress in place and rolled off the bed landing on the floor.<br><br>On 8/12/24 at 2:06 PM the Director of Nursing (DON) stated some staff say the resident can assist by using the grab bars but the care plan does state to use two staff with repositioning. She stated Staff A should have had another staff member with her when repositioning Resident #1.<br><br>On 8/12/24 at 2:59 PM Staff A stated she had assisted Resident #1 with repositioning the night she fell out of bed. She stated she assisted the resident by herself because at that time she was an assistance of one. Staff A stated she did not know anything about being an assistance of two staff for repositioning. When Staff A was informed of the care plan stating at the time of the fall, the resident required the assistance of two staff for repositioning, she stated she did not know that otherwise she would not have gone in there alone to help her.<br><br>(continued on next page) |

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

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

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility provided a policy titled Comprehensive Care Plan with a revision date of 7/18/2022. The policy documented the facility shall provide an individualized, interdisciplinary plan of care for all residents that shall be appropriate to the resident's needs, strengths, results of diagnostic testing, limitations and goals. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074<br><br>Based on clinical record review, facility investigative file review, staff interviews and facility policy review the facility failed to prevent 1 of 3 residents (Resident #1) from sustaining an injury while assisting them with positioning in their bed. Resident #1's care plan documented she required the assistance of two staff with repositioning in bed. On 7/20/24 Resident #1 wanted to be repositioned in bed. Staff A Certified Nursing Assistant (CNA assisted Resident #1 by herself with repositioning in bed when she rolled out of bed and landed on the floor. Resident #1 complained of pain to her hip, left arm and indicated she did hit her head. Resident #1 was taken to the emergency room (ER) and found to have a closed displaced fracture of her left femoral neck that required surgical repair on 7/22/24. The resident returned to the facility on [DATE]. The facility reported a census of 84 residents.<br><br>Findings Include:<br><br>According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 6/11/24 documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14. A BIMS score of 14 suggested no cognitive impairment. The MDS documented she was frequently incontinent of bowel and had no falls since her admission/entry, reentry or prior assessment. The MDS listed the following diagnosis: spina bifida, seizure disorder, anxiety, opioid use, insomnia, and chronic pain syndrome.<br><br>The Care Plan focus area with an initiation date of 6/13/2023 documented Resident #1 was at risk for decline in her activities of daily living (ADLs) related to her diagnoses of spina bifida and seizures. The care plan documented the following intervention with a revision date of 7/15/2024, the resident required total assistance of two staff to reposition in bed. The resident had bilateral grab bars to assist with repositioning.<br><br>The Progress Notes documented the following:<br><br>a) On 7/20/24 at 1:21 AM resident had turned on her call light and wanted help from the Certified Nursing Assistant (CNA) to roll to the other side. Resident tolled to right side and was too close to the edge of the bed, air mattress in place and rolled off the bed landing on the floor.<br><br>b) On 7/24/24 at 5:05 PM resident returned from hospital stay at approximately 11:00 AM. Resident required two-person assistance with a mechanical lift. Her incision site was covered with dressing post op with orders to leave dressing intact until follow up with Orthopedics on 8/7/24.<br><br>Review of a document titled Hospital Discharge Summary with a date of service of 7/23/24 documented a primary discharge diagnosis of closed displaced fracture of the left femoral neck. The resident had surgery to repair the fracture on 7/22/24 with the plan to return back to the facility.<br><br>Review of the facility's investigative file included the following:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | a) On 7/22/24 Staff A Certified Nursing Assistant (CNA) stated Resident #1 had her call light on. She went into her room and the resident had requested that she be moved to her right side. Resident #1 grabbed the grab bar on her bed and Staff A assisted with rolling the resident to her right side. Resident #1's slipped off the grab bar and started to fall to the floor. Staff A went to grab for Resident #1 but was unable to stop her from falling. Staff A called for assistance from other CNA's and nurses on the floor. Resident #1 was complaining of pain, so they did not move her. Staff A placed a pillow under her head and stayed with her until the ambulance crew arrived and transported her to the hospital.<br><br>b) Staff documented on the Fall Scene Investigation Report that assistance per care plan was being provided.<br><br>c) Staff documented the root cause of the fall as the resident being too close to the edge of the air mattress when trying to roll over. The initial intervention put in place to prevent future falls was to ensure staff pull Resident #1 over before rolling to one side.<br><br>d) Investigation determined that Resident #1 had an air mattress on her bed that may have shifted during repositioning, as well as her hand slipping from the grab bar. The bed had brakes engaged and both grab bars were in position.<br><br>On 8/12/24 at 2:06 PM the Director of Nursing (DON) stated Resident #1 had always been able to use the grab bars to assist with repositioning. At the time of the fall, she got too close to the edge of the bed, with her momentum she just kept rolling and fell . The aide that was with her at that time could not get to her quick enough to help. The DON acknowledged there was just one staff assisting her with repositioning at that time. She acknowledged the care plan at that time stated to reposition with two staff assistance and Staff A should have had another staff member with her. Some staff say the resident can assist by using the grab bars but the care plan does state to use two staff with repositioning. She stated they initiated education to all staff on two persons assist, lifting and moving residents in bed. The education went to all CNAs and nurses.<br><br>On 8/9/24 at 11:15 AM Staff C Certified Medication Aide (CMA) stated while she assisted Resident #1 with positioning in bed, she would have another staff member present. Staff C stated Resident #1 can roll to each side by herself but it's hard to assist her by yourself. Resident #1 will try to assist by using the grab bars but she can't hold on to them for that long because she has limited strength.<br><br>On 8/9/24 at 1:48 PM Staff B CNA stated prior to Resident #1's fall she would have another staff member in the room to assist with repositioning her. Staff B indicated that was her own preference so she would not hurt Resident #1.<br><br>On 8/12/24 at 12:07 PM Staff D CMA indicated she would assist Resident #1 with repositioning with another staff member present. She indicated Resident #1 is heavier, having that second person makes it easier to reposition her in bed. She indicated the resident can use the grab bars but was unsure why someone would reposition her in bed alone.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 8/12/24 at 2:59 PM Staff A stated she had assisted Resident #1 with repositioning the night she fell out of bed. She stated she assisted the resident by herself because at that time she was an assistance of one. Staff A stated she did not know anything about being an assistance of two staff for repositioning. When Staff A was informed of the care plan stating at the time of the fall, the resident required the assistance of two staff for repositioning, she stated she did not know that otherwise she would not have gone in there alone to help her.<br><br>The facility provided a policy titled Comprehensive Care Plan with a revision date of 7/18/2022. The policy documented the facility shall provide an individualized, interdisciplinary plan of care for all residents that shall be appropriate to the resident's needs, strengths, results of diagnostic testing, limitations and goals.<br><br>The facility provided a policy titled ADL Services with an effective date of 6/28/17. The policy documented residents shall receive assistance with ADL's every shift, as appropriate. |