STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165524	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Lutheran Home	Seven Elliott Street 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 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** 37074 Based on clinical record review, facility investigation file review, staff and resident interviews, and facility policy review the facility failed to treat 1 of 3 resident (Resident #3) with dignity during medication administration. The facility reported a census of 86 residents. Findings include: According to the admission Minimum Data Set (MDS) assessment tool with a reference date of 1/16/2025 documented Resident #3 had a Brief Interview of Mental Status (MDS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented she refused care for 1-3 days of the 7-day review period. The following diagnoses were listed for the resident: chronic respiratory failure, atrial fibrillation, heart failure, and urine retention. The Care Plan Focus area with an initiation date of 1/15/2025 documented Resident #3 refused care such as medications at times. Staff were instructed to encourage the resident to take her medications as prescribed by her physician. Staff are to notify the physician/hospice provider. The following Progress Notes documented: a) On 2/9/2025 at 8:39 AM resident up to the nurse's station via walker, very confused. Resident denies any other complaints but pain, refused all medications this morning. No redirections are effective. Resident refused breakfast three times. b) On 2/9/2025 at 8:49 AM this nurse and other resident at the nurse's station discussing another matter with back turned to Resident #3. Resident #3 began yelling at this nurse and picked up a [NAME] cup; threw and hit this nurse's chair. Aide coming up hall stated what the heck is going on. Resident then picked up another [NAME] cup and began swinging it around, hitting this nurse in the outside of the left knee. This nurse assisted with sitting resident in a wheelchair and returning to her room. Continued being verbally abusive, accusing aide of killing babies. No redirection effective, medications given, provided safe distance reassurances, and call placed to Hospice. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) On 2/9/2025 at 9:06 AM Resident #3 continues to show agitation and yelling in room. Floor in room covered with water, seen pouring cups of fluid onto floor and into window sill in room. Noted water running in bathroom. Staff removing all objects except bed, recliner and oxygen from room to prevent injury to herself. Floor cleaned and resident is safe in wheelchair. Staff checking every few minutes. Review of the facility's investigative file revealed the following handwritten statements: a) Staff E Registered Nurse (RN) wrote: On 2/9/2025 at approximately 8:30 AM while this nurse was at the nurse's station documenting, Resident #3 approached the nurse's station, propelling her walker with her left hand as right hand was casted. This nurse greeted the resident and Staff B Certified Medication Aide. Offered a chair for the resident to sit in. Resident #3 refused as Staff E sat near the resident and offered a chair two times in the next 10 minutes. Staff B approached the resident and offered the resident an available meal tray and a chair to sit in; but she refused. Resident #3 spoke briefly to another resident discussing her broken arm and the resident stated yes it hurts. Staff E turned to continue charting while continuing to visit occasionally with Resident #3. At approximately 8:40 AM-8:42 AM Staff B approached the resident with a menu and offered to help chose the next day's meal. The resident refused and stated I don't want breakfast or lunch. The resident then took the menu from Staff B and threw it on the floor. Staff B left the area while Staff E remained in the area. At approximately 8:45 AM another resident approached the nurse's station to ask Staff E for a favor. Staff E turned to face that resident and began to discuss her need, taking notes. Immediately an object hit the back of Staff E's chair and she felt moisture. When she looked on the floor it was a [NAME] cup and the other resident stated oh my god, Resident #3 just threw that at us. Staff E stood up and at that time Staff F Certified Nursing Assistant (CNA) approached the nurse's station and stated what the heck happened. Resident #3 grabbed a second [NAME] cup and began swinging it, hitting Staff E on the left lateral knee. The cup was taken away and the resident continued to flail her casted arm at staff. This nurse approached the resident from behind, placed her arms under her upper arms and helped the resident upright without using her hands, just supporting arms and had Staff F placed in a wheelchair behind the resident and she sat down. This nurse instructed Staff F to take the resident to her room to prevent any further injury to property or others. This nurse obtained her as needed (PRN) Ativan and Morphine from the medication aide and returned to the resident's room. Resident #3 continued to kick and flail at staff. This nurse told the resident she was giving her medication to calm her down. Staff F held her head with her right palm on her forehead. This nurse inserted the medication syringes into her left cheek and administered. Staff E then instructed the CNAs that she was going to call the manager on duty and hospice. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) On 2/9/2025 Staff F wrote she was returning residents from the dining room back to their rooms. She passed Resident #3 by the nurse's station, she was to talking to the nurse, Staff E. Staff F passed with different residents twice on her back to the dining room and she saw Resident #3 pick up a [NAME] mug and threw it into the nurse's station where Staff E and another resident were sitting. Staff F said whoa whoa and picked up the [NAME] cup. Staff E stood up and went towards Resident #3 as she picked up another [NAME] mug winging it around and swung it into Staff E's knee. Staff E braced the resident and told Staff F to grab a wheelchair near by so Staff E could sit her down. Staff E asked her to take the resident to her room and she did. Staff E stood there not sure what to do once in her room. Resident #3 was yelling and stated I killed babies and T*** has camera in here watching. Staff E came in with 2 medications and said she had medication to help her calm down and be safe. Staff E took the medication in the syringes, held Resident #3's hands to her chest and told her to brace the resident's head for safety. Staff F used her arms to cradle the residents head while Staff E administered two medications. Staff E kept telling Resident #3 that it was her job to keep her safe. c) On 2/9/2025 Staff B was one of Resident #3's aides. After room trays had arrived some time after 8:30 AM. She stood at the nurse's station speaking with Resident #3 about breakfast and her menu. She asked why the resident did not want to eat breakfast and if she wanted to fill out her menu for tomorrow. She said no and then threw her menu on the floor. Staff B picked it up and told her that we would try later. Staff B then went to the dining room to grab other residents. When she arrived back to the hall, she came up on Resident #3's room where her things were in the hallway and Staff E stated she had been trying to flood her room and was throwing things. Staff B went to get a bath blanket and when she returned she saw Staff F behind the resident and Staff E in front of the resident. Staff F held the resident's head and Staff E just removed a medication syringe away from her. d) Staff C Certified Medication Aide (CMA) wrote on 2/9/2025 she was in the dining room during breakfast passing morning medications when Staff E approached her and said she needed morphine and Ativan for Resident #3. She needed it because she had thrown a [NAME] cup at her while she was talking to another resident. Staff C said she drew up the morphine in the syringe but Staff C did not have another one for the Ativan. Staff E took the bottle with her and returned it when she was done. Staff C asked Staff E if she was able to get Resident #3 to take her medications and Staff E stated she did not give her a choice. e) Staff A CNA wrote on 2/9/2025 while passing room trays, Staff E walked down the hall mad. Stated that Resident #3 was mad, throwing staff's cups at her and another resident. When Staff A was done passing trays she went down to check on Resident #3. When she walked in Staff F was holding Resident #3's head while Staff F was pulling out the medication syringe from her mouth. At that point her and Staff B got her calmed down. Resident #3 told them she can not have morphine due to her hallucinating. On 3/6/2025 at 3:37 PM observed Resident #3 lying in bed, sits up when greeted. When asked how staff were with her, she stated good. She added there was one nurse that got fired because she gave her morphine when she did not want it. She told her she did not want the medication because it made her hallucinate. It was in a liquid form not a pill like she thought it would have been. She denied anyone holding her head or hands during that time. When asked what nurse this was, she was unable to remember her name but knew she was no longer working at the facility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/2025 at 11:25 AM Staff C stated on the morning of 2/9/2025 Resident #3 had refused that morning and she reported that to the nurse, the nurse attempted as well. This was normal for her to refuse medications. When Resident #3 first got to the facility she refused her medications and thought the hospital harmed her. Staff C went up to the dining room to work on her medication pass. After 8:00 AM Staff E came up to her at the medications cart stating she needed morphine (treatment pain) and Ativan (antianxiety) because Resident #3 was throwing [NAME] cups. Staff C drew up the morphine but she did not have enough syringes for the Ativan. Staff E took the bottle with her to administer the medication. Staff C stated she signed out the orders but was not present when they were given. When Staff E brought the medication back up to the medication cart, Staff C asked her if Resident #3 took the medications. Staff E stated she did not give her a choice, but that's all she said. Staff C was asked how Staff E sounded when she said she did not give Resident #3 a choice, she said it sounded awful; just in the wording. Staff C stated she knows they are not to force residents to take their medications, it's their right to not take them. On 3/6/2025 at 1:57 PM Staff F stated she had never worked with Resident #3 prior to 2/9/2025. She was assisting residents to their room after breakfast. Resident #3 was at the nurse's station, picked up a [NAME] cup; started to swing it then threw it in the middle of the nurse's station with another resident and staff member present. Resident #3 picked up a second [NAME] cup, swings it then threw it. It hit Staff E's leg. Staff E asked her to get a wheelchair and they assisted her to the wheelchair. Resident #3 said you killed your babies, random stuff. Once in the wheelchair, Staff E asked her to take her to her room as she yelled and threw her arms around. Staff F stayed with her until Staff E returned and she had two white boxes. Staff E told her to hold her head and a million things ran threw her mind and she knew she was not supposed to touch a resident on the other hand the nurse kept saying it's for her safety, it's for her safety. Staff F was torn because she has never been in the situation before. Staff F cradled Resident #3, her arms were not tight nor were they restricting. Staff F stated she did not know Staff E was going to force medications in Resident #3; she just kept saying it was for her safety. When asked if Resident #3 was given the choice to refuse the medications she sated there was no choice; she kept telling her its to keep you and everyone else safe. She added she felt like Resident #3's rights were stripped from her by not having a choice. On 3/5/2025 at 2:25 PM Staff B stated on 2/9/2025 she walked up to the nurse's station, after breakfast. She asked Resident #3 to fill out her menu and she threw it on the ground. She thought she was joking but Resident #3 was irritated at that point. Staff B went back to the dining room to assist other residents back from breakfast. As she walked down the hall, she noticed the furniture was out of Resident #3's room and she was throwing water on the floor. Staff B went to get blankets and towels to help clean up the water. When she walked around the corner she saw Resident #3 sitting in her wheelchair in her room as Staff F CNA stood behind the resident, holding the resident's head as she was thrashing around in her wheelchair. Staff E was standing in front of Resident #3 and was seen removing a medication syringe from the resident's mouth. Staff B stated she assumed it was Ativan. On 3/5/2025 at 2:39 PM Staff A stated on 2/9/2025 she was assisting with room trays. Staff A stated Staff E walked down the hall mad because Resident #3 threw a [NAME] cup at her. After she finished with room trays, Staff B asked her to go check on Resident #3 with her. Staff A stated Resident #3 was sitting in her room, irate. She walked away then went back in and saw Staff F had her hands on the resident's head and Staff E removed a medication syringe from the resident's mouth. Staff E was asked what she gave her, she indicated it was a pain medication and a medication to calm her down. Staff E and Staff F left the room. Staff B went in the room and was able to calm Resident #3 down. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/2025 at 12:11 PM the Administrator stated their investigation concluded Staff E did not allow Resident #3 the right to refuse the medications. Resident #3 had the right to refuse any of the medications. She believed Staff E should have contacted the resident's physician about what was going on. The Administrator added even in Staff E's statement she said she did not give her the option to not take the medications. On 3/6/2025 at 12:59 PM the Director of Nursing (DON) stated after they interviewed staff and got their statements, the nurse administered medications to Resident #3 that she did not want. She added if the staff would have stepped back and let Resident #3 decompress in a safe area it probably could have been avoided. Resident #3 needed space and time to calm down, to deescalate. On 3/6/2025 at 2:21 PM the Assistant Director of Nursing (ADON) stated during their interview with Staff E, she acknowledged Resident #3 tried to refused the medication. When asked why Staff E did not honor her wishes, she told them she felt Resident #3 was in pain and she was agitated. She was dumping water on the floor and threw a [NAME] cup at her. The ADON stated Staff E should have removed herself from the situation and brought someone else in. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/2025 at 3:02 PM Staff E stated immediately: I am not denying anything, I medicated Resident #3. She added she did not give her time to consent and she supported the fact that she was trying to keep Resident #3, other residents and herself safe. That morning she refused her medications when the CMA attempted to administer them. Staff E then attempted to administer her medications and she again refused. After breakfast Staff E was sitting at the nurse's station and Resident #3 came up to the desk, pushing her walker with her good hand. She was visiting with a resident that lived across the hall from her; they were having a pleasant conversation. Staff E asked the resident if she wanted a chair so she did not fall and she said no. Staff B then approached Resident #3 again to see if she wanted a chair because she was concerned about her falling. She declined the wheelchair offer. Resident #3 continued to talk with the other resident; they talked about her injured arm, how she injured it and if it hurt. Resident #3 was very oriented. They visited for about five minutes. Staff B came back down informed Resident #3 they have a breakfast tray for her and she could sit in a chair out at the desk to eat, allowing her to continue to visit with the resident. Resident #3 said no, I am not eating, it's probably poisoned. Staff B went on with another task. Staff E was charting and Resident #3 was talking with her, when another resident came down the hall and asked Staff E for a favor. She needed to leave a note for the medical supply nurse. Just as she started to write on the note pad, a [NAME] cup hit Staff E chair; in direct line of the other resident. Staff E stood up and Staff F walked down, asked what the heck happened. The resident said Resident #3 threw the [NAME] cup at us. Staff E stated let's get a wheelchair just as Resident #3 threw another [NAME] cup, that ended up hitting Staff E. Staff E assisted Resident #3 into a wheelchair and asked Staff F to take her to her room because she knows she has some medications she can have. Staff E went to Staff C and asked her to draw up morphine and Ativan. When Staff E got to Resident #3's room Staff F was behind the resident as she was throwing things off the dresser, pulled all her blankets on the floor. Staff F added at one-point Resident #3 was going crazy. The resident was pouring water in to the furnace that was on the wall and plugged in to an electrical outlet. Staff E felt Resident #3 was putting herself in danger so she asked Staff F to hold her head while she gave the resident her medications. Staff F had her right palm on the resident's forehead, not in a forceful manner. Staff E told the resident what she was doing, why she was doing it and that she was sorry it had to be done. She told Resident #3 she needed to calm down. Staff E and Staff F stayed in the room until she calmed down. Staff F left the room and called her charge nurse, called hospice and asked for them to come visit. Hospice told her to continue with the Ativan until her behaviors improved. Staff E was asked if Resident #3 was given the option to refuse the medications she gave, she indicated not at that point. She added she had thought about this repeatedly and it's the same when giving someone an as needed (PRN) Intramuscular (IM) injection when they are combative. Staff E stated she used the tools she had to stop the situations: had thrown a [NAME] cup in the direction of another resident, was pouring water into her furnace, and had turned on the water in her room allowing it to continuously run. She was trying to stop a million things and had the tools to do so. The facility provided a policy titled: Facility Responsibilities with a revised date of 3/1/2017. It documented it is the policy of this facility to uphold and comply with the facility responsibilities. The facility must ensure that staff members are educated on the rights of the residents and the responsibilities of a facility to properly care for it's residents. 1. Resident Rights. The resident has a right to a dignified existence, self-determination, and communication and access to person and services inside and outside the facility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) The facility must treat each resident with respect and dignity, and care for each resident in a manner and environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individually. b) The facility must protect and promote the rights of the resident. 2. Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

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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** 37074 Based on clinical record review, facility investigation file review, staff and resident interviews, and facility policy review the facility failed to report an allegation of abuse involving Resident #3 within 2 hours of the allegation. The facility reported a census of 86 residents. Findings include: According to the admission Minimum Data Set (MDS) assessment tool with a reference date of 1/16/2025 documented Resident #3 had a Brief Interview of Mental Status (MDS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented she refused care for 1-3 days of the 7-day review period. The following diagnoses were listed for the resident: chronic respiratory failure, atrial fibrillation, heart failure, and urine retention. The Care Plan Focus area with an initiation date of 1/15/2025 documented Resident #3 refused care such as medications at times. Staff were instructed to encourage the resident to take her medications as prescribed by her physician. Staff are to notify the physician/hospice provider. The following Progress Notes documented: a) On 2/9/2025 at 8:39 AM resident up to the nurse's station via walker, very confused. Resident denies any other complaints but pain, refused all medications this morning. No redirections are effective. Resident refused breakfast three times. b) On 2/9/2025 at 8:49 AM this nurse and other resident at the nurse's station discussing another matter with back turned to Resident #3. Resident #3 began yelling at this nurse and picked up a [NAME] cup; threw and hit this nurse's chair. Aide coming up hall stated what the heck is going on. Resident then picked up another [NAME] cup and began swinging it around, hitting this nurse in the outside of the left knee. This nurse assisted with sitting resident in a wheelchair and returning to room. Continued being verbally abusive, accusing aid of killing babies. No redirection effective, medications given, provided safe distance reassurances, and call placed to Hospice. c) On 2/9/2025 at 9:06 AM Resident #3 continues to show agitation and yelling in room. Floor in room covered with water, seen pouring cups of fluid onto floor and into window sill in room. Noted water running in bathroom. Staff removing all objects except bed, recliner and oxygen from room to prevent injury to herself. Floor cleaned and resident is safe in wheelchair. Staff checking every few minutes. Review of the facility's investigative file revealed the following handwritten statements: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a) Staff E Registered Nurse (RN) wrote: On 2/9/2025 at approximately 8:30 AM while this nurse was at the nurse's station documenting, Resident #3 approached the nurse's station, propelling her walker with her left hand as right hand was casted. This nurse greeted the resident and Staff B Certified Medication Aide. Offered a chair for the resident to sit in. Resident #3 refused as Staff E sat near the resident and offered a chair two times in the next 10 minutes. Staff B approached the resident and offered the resident an available meal tray and a chair to sit in; but she refused. Resident #3 spoke briefly to another resident discussing her broken arm and the resident stated yes it hurts. Staff E turned to continue charting while continuing to visit occasionally with Resident #3. At approximately 8:40 AM-8:42 AM Staff B approached the resident with a menu and offered to help chose the next day's meal. The resident refused and stated I don't want breakfast or lunch. The resident then took the menu from Staff B and threw it on the floor. Staff B left the area while Staff E remained in the area. At approximately 8:45 AM another resident approached the nurse's station to ask Staff E for a favor. Staff E turned to face that resident and began to discuss her need, taking notes. Immediately an object hit the back of Staff E's chair and she felt moisture. When she looked on the floor it was a [NAME] cup and the other resident stated oh my god, Resident #3 just threw that at us. Staff E stood up and at that time Staff F Certified Nursing Assistant (CNA) approached the nurse's station and stated what the heck happened. Resident #3 grabbed a second [NAME] cup and began swinging it, hitting Staff E on the left lateral knee. The cup was taken away and the resident continued to flail her casted arm at staff. This nurse approached the resident from behind, placed her arms under her upper arms and helped the resident upright without using her hands, just supporting arms and had Staff F placed in a wheelchair behind the resident and she sat down. This nurse instructed Staff F to take the resident to her room to prevent any further injury to property or others. This nurse obtained her as needed (PRN) Ativan and Morphine from the medication aide and returned to the resident's room. Resident #3 continued to kick and flail at staff. This nurse told the resident she was giving her medication to calm her down. Staff F held her head with her right palm on her forehead. This nurse inserted the medication syringes into her left cheek and administered. Staff E then instructed the CNAs that she was going to call the manager on duty and hospice. b) On 2/9/2025 Staff F wrote she was returning residents from the dining room back to their rooms. She passed Resident #3 by the nurse's station, she was to talking to the nurse, Staff E. Staff F passed with different residents twice on her back to the dining room and she saw Resident #3 pick up a [NAME] mug and threw it into the nurse's station where Staff E and another resident were sitting. Staff F said whoa whoa and picked up the [NAME] cup. Staff E stood up and went towards Resident #3 as she picked up another [NAME] mug winging it around and swung it into Staff E's knee. Staff E braced the resident and told Staff F to grab a wheelchair near by so Staff E could sit her down. Staff E asked her to take the resident to her room and she did. Staff E stood there not sure what to do once in her room. Resident #3 was yelling and stated I killed babies and T*** has camera in here watching. Staff E came in with 2 medications and said she had medication to help her calm down and be safe. Staff E took the medication in the syringes, held Resident #3's hands to her chest and told her to brace the resident's head for safety. Staff F used her arms to cradle the residents head while Staff E administered two medications. Staff E kept telling Resident #3 that it was her job to keep her safe. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) On 2/9/2025 Staff B was one of Resident #3's aides. After room trays had arrived sometime after 8:30 AM. She stood at the nurse's station speaking with Resident #3 about breakfast and her menu. She asked why the resident did not want to eat breakfast and if she wanted to fill out her menu for tomorrow. She said no and then threw her menu on the floor. Staff B picked it up and told her that we would try later. Staff B then went to the dining room to grab other residents. When she arrived back to the hall, she came up on Resident #3's room where her things were in the hallway and Staff E stated she had been trying to flood her room and was throwing things. Staff B went to get a bath blanket and when she returned she saw Staff F behind the resident and Staff E in front of the resident. Staff F held the resident's head and Staff E just removed a medication syringe away from her. d) Staff C Certified Medication Aide (CMA) wrote on 2/9/2025 she was in the dining room during breakfast passing morning medications when Staff E approached her and said she needed morphine and Ativan for Resident #3. She needed it because she had thrown a [NAME] cup at her while she was talking to another resident. Staff C said she drew up the morphine in the syringe but Staff C did not have another one for the Ativan. Staff E took the bottle with her and returned it when she was done. Staff C asked Staff E if she was able to get Resident #3 to take her medications and Staff E stated she did not give her a choice. e) Staff A CNA wrote on 2/9/2025 while passing room trays, Staff E walked down the hall mad. Stated that Resident #3 was mad, throwing staff's cups at her and another resident. When Staff A was done passing trays she went down to check on Resident #3. When she walked in Staff F was holding Resident #3's head while Staff F was pulling out the medication syringe from her mouth. At that point her and Staff B got her calmed down. Resident #3 told them she can not have morphine due to her hallucinating. On 3/6/2025 at 3:37 PM Resident #3 was lying in bed, sits up when greeted. When asked how staff were with her, she stated good. She added there was one nurse that got fired because she gave her morphine when she did not want it. She told her she did not want the medication because it made her hallucinate. It was in a liquid form not a pill like she thought it would have been. She denied anyone holding her head or hands during that time. When asked what nurse this was, she was unable to remember her name but knew she was no longer working at the facility. On 3/5/2025 at 11:25 AM Staff C stated on the morning of 2/9/2025 Resident #3 had refused meds that morning and she reported that to the nurse, the nurse attempted as well. This was normal for her to refuse medications. When Resident #3 first got to the facility she refused her medications and thought the hospital harmed her. Staff C went up to the dining room to work on her medication pass. After 8:00 AM Staff E came up to her at the medications cart stating she needed morphine (treatment pain) and Ativan (antianxiety) because Resident #3 was throwing [NAME] cups. Staff C drew up the morphine but she did not have enough syringes for the Ativan. Staff E took the bottle with her to administer the medication. Staff C stated she signed out the orders but was not present when they were given. When Staff E brought the medication back up to the medication cart, Staff C asked her if Resident #3 took the medications. Staff E stated she did not give her a choice but that's all she said. Staff C was asked how Staff E sounded when she said she did not give Resident #3 a choice, she said it sounded awful; just in the wording. Staff C stated she knows they are not to force residents to take their medications, it's their right to not take them. (continued on next page)

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	165524	A. Building B. Wing	03/13/2025

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/2025 at 11:41 AM Staff D RN stated a couple of CNAs told her about an incident between a nurse and another CNA the day prior. Staff D stated she was working that day. The CNAs told her when they walked in they saw a CNA holding Resident #3's head and a nurse was removing syringes from the resident's mouth while in her room. When asked who reported this to her, she stated Staff A and Staff B. She told her Staff E was administering the medications and Staff F was the one holding Resident #3's head. After she was told this information, she told her boss as soon as she got to work. She was asked to write a statement and had the CNAs write theirs. On 3/6/2025 at 1:57 PM Staff F stated she had never worked with Resident #3 prior to 2/9/2025. She was assisting residents to their room after breakfast. Resident #3 was at the nurse's station, picked up a [NAME] cup; started to swing it then threw it in the middle of the nurse's station with another resident and staff member present. Resident #3 picked up a second [NAME] cup, swings it then threw it. It hit Staff E's leg. Staff E asked her to get a wheelchair and they assisted her to the wheelchair. Resident #3 said you killed your babies, random stuff. Once in the wheelchair, Staff E asked her to take her to her room as she yelled and threw her arms around. Staff F stayed with her until Staff E returned and she had two white boxes. Staff E told her to hold her head and a million things ran threw her mind and she knew she was not supposed to touch a resident on the other hand the nurse kept saying it's for her safety, it's for her safety. Staff F was torn because she has never been in the situation before. Staff F cradled Resident #3, her arms were not tight nor were they restricting. Staff F stated she did not know Staff E was going to force medications in Resident #3; she just kept saying it was for her safety. When asked if Resident #3 was given the choice to refuse the medications she sated there was no choice; she kept telling her it's to keep you and everyone else safe. She added she felt like Resident #3's rights were stripped from her by not having a choice. After this took place she went to her charge nurse and was told to write a statement. On 3/5/2025 at 2:25 PM Staff B stated on 2/9/2025 she walked up to the nurse's station, after breakfast. She asked Resident #3 to fill out her menu and she threw it on the ground. She thought she was joking but Resident #3 was irritated at that point. Staff B went back to the dining room to assist other residents back from breakfast. As she walked down the hall, she noticed the furniture was out of Resident #3's room and she was throwing water on the floor. Staff B went to get blankets and towels to help clean up the water. When she walked around the corner she saw Resident #3 sitting in her wheelchair in her room as Staff F CNA stood behind the resident, holding the resident's head as she was thrashing around in her wheelchair. Staff E was standing in front of Resident #3 and was seen removing a medication syringe from the resident's mouth. Staff B stated she assumed it was Ativan. When asked how Staff F was holding the resident's head, she sated she caught the tail end of it but she was holding her head at the resident's temples. The resident was still able to trash around. She was not sure if the medications were given or not. When Staff B was asked if she reported what she saw to anyone, she acknowledged she did not. On 3/5/2025 at 2:39 PM Staff A stated on 2/9/2025 she was assisting with room trays. Staff A stated Staff E walked down the all mad because Resident #3 threw a [NAME] cup at her. After she finished with room trays, Staff B asked her to go check on Resident #3 with her. Staff A stated Resident #3 was sitting in her room, irate. She walked away then went back in and saw Staff F had her hands on the resident's head and Staff E removed a medication syringe from the resident's mouth. Staff E was asked what she gave her, she indicated it was a pain medication and a medication to calm her down. Staff E and Staff F left the room. Staff B went in the room and was able to calm Resident #3 down. When asked if she reported this to staff, she stated she reported it to the on-call manager as soon as she came upstairs. She came upstairs after Staff E called her that same day. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/2025 at 12:11 PM the Administrator stated their investigation concluded Staff E did not allow Resident #3 the right to refuse the medications. Resident #3 had the right to refuse any of the medications. She believed Staff E should have contacted the resident's physician about what was going on. The Administrator added even in Staff E's statement she said she did not give her the option to not take the medications. The Administrator stated the incident took place on 2/9/2025 and management was informed on 2/10/2025. Staff were educated on reporting if they feel something is not right. There also educated on reporting allegations of abuse, misconduct or if something is questionable. She advised if they have to question anything to call her, they have her cell phone number. On 3/6/2025 at 3:02 PM Staff E stated immediately: I am not denying anything, I medicated Resident #3. She added she did not give her time to consent and she supported the fact that she was trying to keep Resident #3, other residents and herself safe. That morning she refused her medications when the CMA attempted to administer them. Staff E then attempted to administer her medications and she again refused. After breakfast Staff E was sitting at the nurse's station and Resident #3 came up to the desk, pushing her walker with her good hand. She was visiting with a resident that lived across the hall from her; they were having a pleasant conversation. Staff E asked the resident if she wanted a chair so she did not fall and she said no. Staff B then approached Resident #3 again to see if she wanted a chair because she was concerned about her falling. She declined the wheelchair offer. Resident #3 continued to talk with the other resident; they talked about her injured arm, how she injured it and if it hurt. Resident #3 was very oriented. They visited for about five minutes. Staff B came back down informed Resident #3 they have a breakfast tray for her and she could sit in a chair out at the desk to eat, allowing her to continue to visit with the resident. Resident #3 said no, I am not eating, it's probably poisoned. Staff B went on with another task. Staff E was charting and Resident #3 was talking with her, when another resident came down the hall and asked Staff E for a favor. She needed to leave a note for the medical supply nurse. Just as she started to write on the note pad, a [NAME] cup hit Staff E chair; in direct line of the other resident. Staff E stood up and Staff F walked down, asked what the heck happened. The resident said Resident #3 threw the [NAME] cup at us. Staff E stated let's get a wheelchair just as Resident #3 threw another [NAME] cup, that ended up hitting Staff E. Staff E assisted Resident #3 in to a wheelchair and asked Staff F to take her to her room because she knows she has some medications she can have. Staff E went to the Staff C and asked her to draw up morphine and Ativan. When Staff E got to Resident #3's room Staff F was behind the resident as she was throwing things off the dresser, pulled all her blankets on the floor. Staff F added at one-point Resident #3 was going crazy. The resident was pouring water in to the furnace that was on the wall and plugged in to an electrical outlet. Staff E felt Resident #3 was putting herself in danger so she asked Staff F to hold her head while she gave the resident her medications. Staff F had her right palm on the resident's forehead, not in a forceful manner. Staff E told the resident what she was doing, why she was doing it and that she was sorry it had to be done. She told Resident #3 she needed to calm down. Staff E and Staff F stayed in the room until she calmed down. Staff F left the room and called her charge nurse, called hospice and asked for them to come visit. Hospice told her to continue with the Ativan until her behaviors improved. Staff E was asked if Resident #3 was given the option to refuse the medications she gave, she indicated not at that point. She added she had thought about this repeatedly and it's the same when giving someone an as needed (PRN) Intramuscular (IM) injection when they are combative. Staff E stated she used the tools she had to stop the situations: had thrown a [NAME] cup in the direction of another resident, was pouring water in to her furnace, and had turned on the water in her room allowing it to continuously run. She was trying to stop a million things and had the tools to do so. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided a document titled Nursing Facility Abuse, Prevention, Identification, Investigation and Reporting Policy. The policy documented 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. This includes prohibiting nursing facility staff from taking part in acts that result in person degradation, including the taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and/or recordings on social media or through multimedia messages. 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. It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property. These procedures shall include the screening and training of employees, protection of residents and the prevention, identification, investigation, and timely reporting of abuse, neglect, mistreatment, and misappropriation of property, without fear of recrimination or intimidation. Reporting: All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of Resident abuse shall be reported to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation is made.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on observations, staff interviews, clinical record review, and policy review the facility failed to review and revise the Care Plans for 2 of 7 residents reviewed (Resident #5 and Resident #6). The facility failed to revise the interventions for a resident who sustained falls and a resident who had a significant change. The facility reported a census of 86 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #5 scored 5/15 on the Brief Interview for Mental Status (BIMS) score indicating severe cognitive impairment. The document revealed diagnoses of heart failure, benign prostatic hyperplasia, and urinary tract infection (UTI) in the last 30 days. The document revealed the resident had an indwelling catheter and was always incontinent of bowel. The MDS indicated the resident received hospice care services. Observed on 3/7/2025 at 11:30 AM Resident #5 asleep in bed, catheter bag at foot of bed on the right side with a dignity bag over it, and the call light with reach. Observed on 3/11/25 at 1:30 PM the resident lying in bed semi-alert with the head of the bed and knees elevated with foot protectors in place. The catheter bag was on the right side of the foot of the bed and the call light was within reach. Continuous observation on 3/12/25 at 7:40 AM Staff G, Certified Nursing Assistant (CNA) completing a bed bath with Resident #5. Staff G wore personal protective equipment (PPE). Staff A, CNA, and Staff H, CNA knocked and entered the room to ask if they could be of assistance. Staff A and Staff H offered to complete catheter care for Staff G. Staff A and Staff H completed hand hygiene and donned PPE. While Staff A was preparing for catheter care, Staff G and Staff H repositioned Resident #5 in bed. Staff A placed a barrier on the floor and the graduated cylinder on the barrier. Staff H completed the emptying of the catheter with Staff A providing the alcohol wipes. Staff H and Staff A completed the task with removal of the cylinder, and bagging the linens. Staff H and Staff A completed hand hygiene and removed bagged trash and linens from the room. Staff G remained in the room and completed the clean up from the bed bath. The resident had no complaints of pain during the observation, and no signs of redness or skin irritability. Resident #5's Care Plan, dated 3/3/25, revealed the resident received hospice care (initiated 2/25/25). A focus area identified the resident's ability to complete activities of daily living (ADLs) initiated 2/18/25 with interventions of physical therapy/occupational therapy for strengthening/endurance (2/18/25), and to report further deterioration in status to the physician (2/18/25). The Care Plan failed to identify the resident's transfer status, and positioning needs. The document failed to have revisions regarding the need for therapy services and reporting deterioration to the physician. The Care Plan failed to identify the resident had a catheter. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Electronic Medical Record (EMR) Progress Notes revealed on 2/23/25 Resident #5 was admitted to the hospital with a UTI with hematuria. An entry dated 2/25/25 revealed the resident was readmitted to the facility from the hospital and was meeting with hospice. A Progress Note dated 2/26/25 revealed the resident had a Foley catheter in place and was patent. An entry dated 3/3/25 revealed the resident required a Significant Change Assessment as the resident was no longer on skilled services and was on hospice care. On 3/6/25 at 1:16 PM the Director of Nursing (DON) stated Resident #5 was in the hospital with a deep vein thrombosis. The DON reported she was not sure if the resident had any compromised skin on his buttocks. The DON indicated she thought the resident was compliant with care. On 3/6/25 at 2:36 PM the Assistant Director of Nursing (ADON) stated the resident had a fall prior to coming to the facility and had bruising to his face and arms. The ADON reported Resident #5 had an excoriation in the brief area. The ADON stated the resident was pleasant, cooperative, and had not voiced any concerns with being at the facility. On 3/12/25 at 9:15 AM Resident #5 stated he had no concerns with his care. The resident stated he appreciated the staff; the staff were doing a very good job and were always pleasant. Resident #5 stated he had no concerns with his care. On 3/12/25 at 12:30 PM Staff A stated the resident had a 5 day stretch of bed rest and that had ended on 3/10/25. Staff stated they tried to get Resident #5 up earlier this week and the resident has significant complaints of pain and asked to go back to bed. Staff reported they ask the resident if he wanted to get up and he declined. The staff stated the resident requires the use of a dependent mechanical non-weight bearing lift for all transfers. Staff A stated the resident will feed himself when positioned upright in bed. On 3/12/25 at 12:55 PM the DON stated the staff responsible for Care Plans was not in the building and was a full time student. The staff stated Resident #5 should have positioning and transfer interventions on the Care Plan. The DON reported there was a Care Sign in each resident's room on their closet door for an at a glance reference for staff reference. Review of Resident #5's Care Sign on his closet door with the DON revealed transfers with assistance of 2 with a front wheeled walker. The DON acknowledged it was incorrect and corrected it to Hoyer (dependent mechanical non-weight bearing lift) for transfers. 2. According to the MDS assessment dated [DATE] Resident #6 scored 15/15 on the BIMS indicating normal cognition. The document revealed diagnoses of Non-Alzheimer's Dementia and a wedge compression fracture of the thoracic vertebrae. The document revealed the resident was frequently incontinent of bowel and bladder. The MDS indicated the resident required substantial assistance for rolling and sitting to/from lying positions. The document revealed sit to/from stand and transfers required partial moderate assistance. The document revealed that it was unsafe for Resident #6 to ambulate 10 feet. Observed on 3/6/2025 at 11:23 AM the resident in recliner asleep with a sling under him, call light within reach, gripper socks on, and a wheelchair (w/c) at the foot of his bed, not within reach. Observed at 1:46 PM the resident asleep in his recliner, sling under him, and call light within reach. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observed on 3/7/2025 at 11:37 AM the resident asleep in his recliner, feet elevated, pillow under his legs, sling behind him, and the call light within reach. Observed on 3/11/25 at 1:45 PM Resident #6 sleeping in a recliner with his lower extremities elevated on a pillow and gripper socks on. The resident had a call light within reach. The resident was seated on a pressure relief cushion and a dependent lift sling. Continuous observation on 3/12/25 at 6:50 AM with Staff I, CNA, and Staff K, CNA, providing care to Resident #6. Staff I and K knocked, entered the resident's room, asked the resident if he was ready to get up, and the resident agreed. The staff proceeded to go into the bathroom, completed hand hygiene, and donned PPE. Observed the resident positioned in bed in the low position and a sign posted reminding the resident to use a call light for assistance. Staff K assisted the resident with rolling and positioning in bed while Staff I completed peri care. Staff K completed peri care with technique of maintaining separate dirty and clean hands. Staff K noted Resident #6's bandage on the buttock had been dislodged and required nursing assistance to change. Staff J, Licensed Practical Nurse (LPN), knocked, entered the room, completed hand hygiene, and donned PPE. Staff J completed wound care with good technique. Staff J completed hand hygiene, donned new gloves, and assisted the staff with positioning and rolling the resident for donning a new brief and pants. Staff I and Staff K proceeded to place a dependent mechanical lift sling in place and prepared to transfer Resident #6 to his recliner. The staff positioned the resident in the recliner on a pressure relief cushion with his legs elevated, a pillow under his legs, and the call light within reach. The staff completed hand hygiene, and removed the trash and dirty linens. Observed on 3/12/25 at 11:25 AM Resident #6 seated on the recliner with legs elevated, pressure relief cushion present, gripper socks on, and the call light within reach. CNA K was exiting the room with the dependent mechanical lift. Observed on 3/12/25 at 12:35 PM CNA K feeding the resident while positioned in bed in the lowered position with head of bed elevated. Observed on 3/12/25 at 12:43 PM Resident #6 was resting in a lowered bed, pressure relief cushion on the recliner, and no Dycem (non-slip material) present on the recliner. Resident #6's Care Plan dated 2/10/25 revealed a focus area identifying the resident as having a risk for injury from falls dated 12/18/24. The interventions for staff included non-skid socks when shoes were not on (1/4/25), anti-rollbacks to w/c (1/27/25), keep walker within reach (2/3/25), Dycem on recliner with a sign reminding the resident to use a call light (12/18/24), restorative nursing walking program 3 times/day with assistance of 1 with w/c to follow (1/27/25), and transfers with assistance of 1 with front wheeled walker (FWW) (initiated 12/18/24 and revised 1/24/25). The Care Plan failed to identify the change in transfer techniques, the use of a pressure relief cushion on the recliner, the bed in a lowered position, and enhanced barrier precautions. The EMR Progress Notes reviewed from 2/6/25 to 3/7/25 revealed entries of the resident self transferring in his bedroom and bathroom, waking up in the night and sitting on the edge of his bed, and falling with and without injury. A Progress Note dated 2/28/25 revealed the resident sustained an unwitnessed fall in his bedroom, transferred to the hospital, and admitted with a right hip fracture. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/25 at 3:05 PM Resident #6 stated he fell when he was getting up to go shave as his spouse was wanting to go shopping. The resident remained in the mindset that he had been at home when the fall occurred. The resident was seated on a pressure relief cushion on the recliner with his legs elevated and on a pillow, gripper socks on, dependent mechanical lift sling present, and call light within reach. On 3/12/25 at 7:10 AM Staff I stated Resident #6 had previously resided in another part of the building and had provided care to the resident. The staff stated the resident required frequent walk [NAME] as the resident had a strong history of getting up without assistance and was a high fall risk. On 3/12/25 at 10:55 AM Staff J stated a fall intervention for Resident #6 included moving the resident to a room close to the nurses station (the current room is across from the nurses station). The staff stated the resident moved to this room on 2/4/25. The staff stated when the resident was in the previous room the bed was put in the low position as a fall intervention. On 3/12/25 at 11:25 AM Staff K stated fall interventions for the resident included putting a pillow under legs to prevent sliding forward in the recliner, and the bed lowered when the resident is in it. The staff stated they could not speak to interventions when the resident used the wheelchair as the resident does not use the wheelchair that often. On 3/12/25 at 12:47 PM the DON stated the staff responsible for Care Plans was not in the building and is a full time student. The staff stated Resident #6 should have Dycem under the cushion on the recliner as it was still a fall intervention. The DON acknowledged the pressure relief cushion should be on the Care Plan if it was not. The staff reported the pillow under the legs was used as a positioning aid to prevent skin breakdown due to the resident's risk for compromised skin. The DON reported the bed being lowered was not a fall intervention for the resident. The DON stated the transfers on the Care Plan should be the same as what the resident is doing. The staff reported there was a Care Sign in each resident's room on their closet door for an at a glance reference for staff reference. Review of the Care Sign in Resident #6's room with the DON revealed interventions including the use of a Hoyer lift, keep walker in reach, non ambulatory, and Dycem on recliner. The DON discontinued the reference to keep the walker within reach of the resident. The DON acknowledged the bed was in a low position and there was no Dycem present on the recliner. The DON stated the facility had been completing Care Plan Audits, but needed to do more as there were still areas to improve as things were being missed. The DON also indicated staff education needed to be completed on positioning aids. On 3/12/25 at 3:20 PM Staff L, CNA, stated she worked the overnight shift and had not witnessed the resident attempt to get out of bed in the middle of the night. Staff L reported the resident would wake up at night, but would then go back to sleep. The staff stated the resident would have complaints of pain when rolling and repositioning in bed. Staff L stated she saw Resident #6 seated on the edge of the bed on 2/28/25 around 5:30 AM, and assisted him with dressing, transferred him with a gait belt and walker to his recliner, and provided him with the call light. The staff stated she had not witnessed the resident attempt to sit on the edge of the bed since returning from the hospital with a fractured hip. On 3/12/25 at 1:45 PM the Administrator expected that the Care Plans were updated to match the resident needs. The Administrator stated the facility had been working on processes to ensure the Care Plans were updated, but admitted there was still work to be done (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Comprehensive Care Plan, revised 7/18/22 revealed the Care Plan shall be appropriate to the resident's needs, strengths, limitations, and goals. The policy disclosed there should have regular reviewing and revising of the plan for care, treatment and services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165524	A. Building B. Wing	03/13/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on clinical record review, facility investigation file review, staff interviews and facility policy review the facility failed to use professional standards while administering Resident #3's medications. The facility reported a census of 86 residents. Findings include: According to the admission Minimum Data Set (MDS) assessment tool with a reference date of 1/16/2025 documented Resident #3 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented she refused care for 1-3 days of the 7-day review period. The following diagnoses were listed for the resident: chronic respiratory failure, atrial fibrillation, heart failure, and urine retention. The Care Plan Focus area with an initiation date of 1/15/2025 documented Resident #3 refused care such as medications at times. Staff were instructed to encourage the resident to take her medications as prescribed by her physician. Staff are to notify the physician/hospice provider. The following Progress Notes documented: a) On 2/9/2025 at 8:39 AM resident up to the nurse's station via walker, very confused. Resident denies any other complaints but pain, refused all medications this morning. No redirections are effective. Resident refused breakfast three times. b) On 2/9/2025 at 8:49 AM this nurse and other resident at the nurse's station discussing another matter with back turned to Resident #3. Resident #3 began yelling at this nurse and picked up a [NAME] cup; threw and hit this nurse's chair. Aide coming up hall stated what the heck is going on. Resident then picked up another [NAME] cup and began swinging it around, hitting this nurse in the outside of the left knee. This nurse assisted with sitting resident in a wheelchair and returning to room. Continued being verbally abusive, accusing aide of killing babies. No redirection effective, medications given, provided safe distance reassurances, and call placed to Hospice. c) On 2/9/2025 at 9:06 AM Resident #3 continues to show agitation and yelling in room. Floor in room covered with water, seen pouring cups of fluid onto floor and into window sill in room. Noted water running in bathroom. Staff removing all objects except bed, recliner and oxygen from room to prevent injury to herself. Floor cleaned and resident is safe in wheelchair. Staff checking every few minutes. Review of Resident #3's March 2025 Medication Administration Record (MAR) revealed the following orders: a) Ativan (antianxiety) constitute 2 milligrams(mg)/milliliters(mL), give 0.75 mL sublingually as needed (PRN) for anxiety with a start date of 1/16/2025 and end date of 2/9/2025. The order was signed out as being given by Staff C Certified Medication Aide (CMA) on 2/9/2025 at 8:49 AM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) Morphine (treatment of pain) solution 20 mg/mL, give 0.75 mL sublingually every 1-hour PRN for moderate to severe pain, with a start date of 2/8/2025 and end date of 2/10/2025. The order was signed out as being given by Staff C on 2/9/2025 at 8:49 AM. On 3/5/2025 at 11:25 AM Staff C stated on the morning of 2/9/2025 Resident #3 had refused meds that morning and she reported that to the nurse, the nurse attempted as well. This was normal for her to refuse medications. When Resident #3 first got to the facility she refused her medications and thought the hospital harmed her. Staff C went up to the dining room to work on her medication pass. After 8:00 AM Staff E came up her at the medications cart stating she needed morphine (treatment pain) and Ativan (antianxiety) because Resident #3 was throwing [NAME] cups. Staff C drew up the morphine but she did not have enough syringes for the Ativan. Staff E took the bottle with her to administer the medication. Staff C stated she signed out the orders but was not present when they were given. When Staff E brought the medication back up to the medication cart, Staff C asked her if Resident #3 took the medications. Staff E stated she did not give her a choice but that's all she said. On 3/6/2025 at 12:59 PM the Director of Nursing (DON) stated Staff C acknowledged she drew up the morphine, gave Staff E the box that had the Ativan medication in it, signed out the medication but did not administer them. Staff E administered the medications. The DON stated she spoke to Staff C about this and educated her on it after she acknowledged she was not supposed to do that. The DON stated Staff C should have let Staff E draw up the medications, sign them out and administer them or Staff C should have drawn them up, sign them out and administer them. On 3/6/2025 at 3:02 PM Staff E stated immediately: I am not denying anything, I medicated Resident #3. Resident #3 had behaviors that morning and told another resident she was in pain. Staff E went to Staff C and asked her to draw up morphine and Ativan. When Staff E got Resident #3's room Staff F was behind the resident as she was throwing things off the dresser, pulled all her blankets on the floor. Staff F added at one-point Resident #3 was going crazy. The resident was pouring water in to the furnace that was on the wall and plugged in to an electrical outlet. Staff E felt Resident #3 was putting herself in danger so she asked Staff F to hold her head while she gave the resident her medications. Staff F had her right palm on the resident's forehead, not in a forceful manner. Staff E told the resident what she was doing, why she was doing it and that she was sorry it had to be done. She told Resident #3 she needed to calm down. Staff E and Staff F stayed in the room until she calmed down. Staff E acknowledged Staff C drew up the morphine in the dining room and Staff E drew up the Ativan in Resident #3's room. Staff C signed out the medications as being given. The facility provided a document titled Medication Administration with a revision date of 6/30/2023. The policy read that medications shall be stored in a locked medication cart and/or medication room. Medications shall be administered per physician order. Procedure: -open medication cart, -remove medication, check labels with MAR, -dispense medications, -return medications to cart, close and lock the medication cart, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-identify the resident. Administer the medication. Assure resident has taken the medication. Sign medication on the MAR, -Whenever medications are administered on an as needed (PRN) basis, the staff administering the dose is responsible for documenting the administration. CMA's must check with the licensed nurse prior to administering a PRN medication. The nurse will be responsible for assessing the need and effectiveness of the PRN medication.