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	05/30/2025

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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 37074 Based on clinical record review, facility policy review, staff interviews, and the provider interview, the facility failed to ensure the orders of 1 of 3 residents (Resident #2) were implemented after a 30-day review was completed by the ordering Nurse Practitioner. Resident #2 was ordered morphine sulfate (opioid used to treat severe pain) 15 milligrams (mg) twice a day (BID) for pain. The order was a durational order to be reviewed every 30 days by the Nurse Practitioner for continued use. During the Nurse Practitioner's visit with the resident on 3/20/2025 she noted to continue with the scheduled and as needed (PRN) orders for morphine. The Nurse Practitioner documented on 3/31/2025 that staff notified the provider the resident had not received her scheduled morphine since the March 18, 2025. Facility phoning pharmacy to see what occurred. Morphine was an active order on the Medication Administration Record (MAR). She ordered to give a dose now and order for one additional dose to be given to bridge until scheduled dose arrives. During the time Resident #2 was without her scheduled morphine she experienced withdrawal symptoms and was sent to the emergency room (ER) for evaluation. The facility reported a census of 88 residents. Findings include: According to Resident #2's Quarterly Minimum Data Set (MDS) assessment tool with a reference date of 3/7/2025, she had a Brief Interview of Mental Status (BIMS) score of 3. A BIMS score of 3 suggested severe cognitive impairment. The MDS documented she received an antidepressant and an opioid 7 days of the 7 day review period. The MDS listed the following diagnoses: dementia, anxiety, depression, and restless leg syndrome. The Care Plan Focus Area with an initiation date of 8/15/2024 documented Resident #2 had chronic pain related to her diagnosis of osteoarthritis. The Care Plan encouraged staff to administer medications as ordered, monitor for signs and symptoms of narcotic overdose and report to the physician, and notify the physician if interventions are unsuccessful or if current complaint is a significant change from past experience with pain. Record review revealed an Order Summary Report for Resident #2 dated 3/6/2025, listed morphine sulfate (opioid used to treat severe pain) tablet 15 mg, 1 tablet BID for 30 days. A start date of 2/18/2025 was listed and an end date of 3/19/2025 was listed. The Order Summary Report was signed by the resident's physician on 3/19/2025. Record review revealed the following encounter notes completed by Staff H A Registered Nurse Practitioner (ARNP): (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	a) 3/20/2025: continue morphine scheduled and PRN. b) 3/24/2025: Resident #2 was seen today after she had an emergency room visit for hypertension, vomiting and diarrhea. Diarrhea is still present however nausea has resolved. Spoke with the resident's daughter regarding aggressive bowel regimen resident is currently on and whether we should hold this with current diarrhea. She would like this not to be adjusted as she fears it may result in constipation. She does not appear to be in any distress or pain denies any current pain. Since returning from the ER, is currently on 2 liters (L) of oxygen (O2) via nasal cannula. Staff report diarrhea and no falls reported. Continue morphine scheduled and as needed. c) 3/31/2025: staff notified provider that the patient had not received her scheduled morphine since the 18th. Facility phoning pharmacy to see what occurred. Morphine is still on the Medication Administration Record (MAR) as active. Will give a dose x1 now and order for one additional dose to be given to bridge until scheduled dose arrives. Spoke with daughter regarding issue and plan moving forward. Hospice consult today. Review of Resident #2's March 2025 Medication Administration Record (MAR) revealed the following orders: a) morphine sulfate 15 mg, 1 tablet BID for 30 days, with a start date of 2/18/2025. The order was signed out as last given on 3/19/2025 at 7:00 PM. b) morphine sulfate 15 mg, 1 tablet BID for 30 days, with a start date of 3/31/2025 at 7:00 PM and end date of 4/2/2025 at 1:29 PM. The resident went 11 days without her scheduled BID morphine. Record Review revealed the following Progress Notes for Resident #2: a) 3/22/2025 at 9:52 AM at around 8:20 AM, staff reported to this nurse that resident has been, continuously vomiting and having diarrhea all morning and that it is bile. At 8:24 AM assessed the resident: blood pressure 229/97 (via right arm lying) pulse was 87 beats per minutes, respirations were 20 breaths per minutes, temperature 97.6, oxygen saturation was 92% on room air, unable to assess pain verbally with a number, but she does respond with, yes, when asked if she is in pain. Nonverbal signs of pain are present such as withdrawing extremities with movement, grimacing, moaning, generalized trembling, etc. Overall resident's color does not appear normal, she is red in the face and chest area and warm to touch. Trembling is consistent. Lung sounds are abnormal also upon auscultation. She is unable to respond with more than one word answers. This nurse did give report to emergency room nurse via telephone as well. Will get update from hospital at a later time. b) 3/22/2025 at 4:04 PM, Resident #2 returned from emergency room at 2:30 PM with no new orders. Resident received Zofran (antinausea), morphine, Lisinopril (treat high blood pressure), and contrast dye for a CT scan during her visit. Residents' daughter is aware and came to visit her mother when she returned. Resident's vitals taken upon arrival: temperature 97.8, respirations 18, oxygen saturations 95% on room air, blood pressure 135/69, and pulse 85. c) 3/24/2025 at 2:38 PM, referral sent to hospice. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	d) 3/29/2025 at 6:05 PM daughter reported that Resident #2 was unable to swallow liquids or solids at lunch today. That the resident said hungry but once her mouth opened food would tumble out. Great seems at peace at this time with this process. Made clear that she is not interested in a feeding tube and hospice is the way to go. e) 3/30/2025 at 2:23 PM unable to swallow medications today. Resident does open up mouth but is not swallowing. Did eat bites of food today only. Did have loose stool today. f) 4/1/2025 at 10:43 AM this nurse went into resident's room. Resident flaccid and lethargic. Blood pressure was 87/58 P 89 respirations shallow, oxygen saturations 62% on room air; 3 liters (L) of oxygen via nasal cannula applied. Blood pressure rechecked 120/75, oxygen saturations 100%. g) 4/1/2025 at 7:44 PM Resident #2 is non-verbal, arouses to verbal stimuli. She has mottling to bilateral hands, knees and feet. h) 4/2/2025 at 5:36 AM this nurse called to the resident's rooms, staff reported she has stopped breathing. Cessation of respirations, pulse and blood pressure at 2:27 AM. The Death Certificate dated 4/8/25 documented Resident #2's date of death as 4/2/25. The immediate cause of death documented as advanced dementia. Other significant conditions documented as one episode of opioid withdrawal that occurred and resolved more than one week prior to death. Likely physiological stress during that occurrence. On 5/29/2025 at 10:31 AM the Assistant Director of Nursing (ADON) was asked what happened when Resident #2 did not receive her morphine for 11 days, she stated the new order was not written on 3/20/2025 when Staff H rounded, which meant there was not a script at the pharmacy to fill. The order was just in her notes. Since then, they have put in place for staff to review orders with the physician's after they round to review and put the orders in place. She acknowledged the nurses should have noticed the order was not in place anymore. She added at that time they had a lot of different nurses working different halls, so the continuity of nurses was not there. When asked what should have happened after Staff H rounded that day, she stated the order should have been written for Resident #2's morphine and sent to the pharmacy. The notes that were written that day should have been glanced at and read through for additional orders. The ADON was not aware of the resident not receiving her morphine until hospice caught it during their evaluation. On 5/29/2025 at 11:35 AM the Director of Nursing (DON) stated her understanding on what happened with Resident #2's morphine order was it was a durational order that did not flag the pharmacy to send an e-script to be refilled like they do for the other narcotics. When they asked the pharmacy to investigate they determined the order was written for 30 days but they did not see an order for it to be refilled. Resident #2 had been on morphine for so long, someone should have noticed it was not ordered. When hospice came in for an evaluation, they noticed the order was not on her MAR. They got ahold of Staff H for a new order. The DON acknowledged Resident #2 did experience opioid withdrawal. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	On 5/29/2025 at 1:55 PM Staff H, the ARNP, stated normally the pharmacy would send a renewal request when medications are ordered for a duration. She was unaware the order had been stopped because when she looked at the MAR it was still an active order, so she never got a renewal request. She was unsure why the medication was stopped, she should have been active but they never got a refill from the pharmacy. When she was made aware of Resident #2 not receiving her scheduled morphine, she ordered for the dose to start that same day. The facility provided a policy titled Physician Visits, Medical Orders, Delegations of Tasks; with an effective date of 7/1/2021. The policy indicated all residents admitted to this facility must be under the direct supervision of a primary care provider. Only those primary care providers who are currently licensed by the state to practice medicine shall be allowed to do so. Medical orders shall be renewed and updated as applicable or needed. The policy stated members of the interdisciplinary team shall provide care, services, and treatment according to the most recent medical orders and according to laws, regulations and standards of practice.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37074 Based on clinical record view, observation, staff and resident interviews, and facility policy review the facility failed to transfer 1 of 4 residents (Resident #3) in a way that would prevent an accident. The facility reported a census of 88 residents. Findings include: According to the Admission Minimum Data Set (MDS) assessment tool with a reference date of 4/11/2025 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 utilized a walker for mobility and had an impairment on one side of her upper extremity. Resident #3 required supervision or touching assistance to go from a sitting to lying position, lying to sitting position and partial/moderate assistance to go from a sitting to standing position, chair/bed to chair transfer and toileting transfer. The MDS documented the following diagnoses for Resident #3: urinary tract infection (UTI), atrial fibrillation, depression, and toxic encephalopathy. The Care Plan Focus Area with an initiation date of 4/14/2025 documented Resident #3 was at risk for falling related to (what is causing the falls, what did you identify in your CAA documentation as contributing factors). The Care Plan documented a fall on 4/14/2025: her knee gave out during assistance with one staff. Resident #3's transfer status changed to the assistance of two staff with a gait belt. The Progress Notes for Resident #3 documented the following: On 4/30/2025 at 9:50 AM Resident #3 complained of her fourth toe on her left foot being hit; toe is red with a small bruise in the toenail. On 4/30/25 at 10:15 AM resident complaining of pain in her left 4th toe. Range of motion within normal limits for all toes. The 1st to 3rd toes were purplish in color which appeared from decreased circulation and resident's legs being dependent. 4th toe reddened with dark purple bruising noted to nail bed and 5th toe normal skin tone. Provider and family notified of resident's toe being bumped. On 5/27/2025 at 2:31 PM Resident #3 stated a staff member trained her with the mechanical lift alone. She was later told that staff are not to use those lifts alone, they needed to use two people. She was unsure if the staff member stepped on her toe, rolled the bedside table on it or what happened but her toe was hurting after the transfer that day. She indicated her toenail on that toe was still black. Observed her fourth toenail on her left foot to be black at the base and the tip of the nail was natural in color. She denied pain during the interview. On 5/27/2025 at 3:01 PM the Assistant Director of Nursing (ADON) stated Resident #3 was an assistance of two staff, pivot transfer or the use of two staff and a mechanical lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/27/2025 at 3:13 PM the Administrator stated the care sheet in Resident #3's room stated she was an assistance of one staff for transfers when it should have been updated to the use of two staff for transfers. Staff have since been educated on the use care plans, and they have implemented cheat sheets that are printed every morning and updated every day. On 5/27/2025 at 3:23 PM Staff A CNA stated she attempted to assist Resident #3 to her recliner but the resident had issues with standing up. She went to look for help but could not find another staff member. She got Resident #3 hooked up to use the mechanical lift but again could not find another staff to assist her. She unhooked the resident from the lift, placed it on the bathroom, stood Resident #3 up and assisted her to her recliner. Staff A stated she used the gait belt and walker when she assisted Resident #3 to her recliner. At the time the care sheet that was in her room stated she was an assistance of one staff with a gait belt and walker. When asked what her care plan stated her assistance level was at that time, Staff A stated she was not sure what it said in the computer. She stated she used the care sheet that was in her room for transfer assistance information. Staff A indicated she found out later she was an assistance of two staff with a gait belt and walker. On 5/29/2025 at 10:26 AM Staff B Certified Nursing Assistant (CNA), Staff C CNA and Staff D Certified Medication Aide) assisted Resident #3 from her wheelchair to the bathroom with an EZ stand (mechanical lift). On 5/29/2025 at 11:35 AM the Director of Nursing (DON) stated they do not have the care sheets in the resident's rooms anymore. When they were using them the Wound Care/Restorative Nurse was responsible for updating them. The have replaced the care sheets with a cheat sheet that gets updated daily as changes are reported through the therapy department. These sheets will tell the staff members how residents transfer, if they have a restorative program and if they are a priority lay down. When the CNAs come in for their shifts, they get a fresh copy for their shift. After their shift, they are to throw them away, not pass them off on to the next shift since they do change. The facility provided a policy titled Lift and Transfer Training with an effective ate of 11/17/18. The policy indicated all nursing staff shall be oriented to facility lifting and transferring techniques upon hire and on an ongoing basis. The facility provided a policy titled Comprehensive Care Plan with a revised date of 7/18/2022. The policy stated care, treatment and services shall be planned to ensure that they are individualized to the resident's needs. This 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