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	05/21/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, document review, staff interviews and policy review the facility failed to protect a resident from misappropriation of property when a resident's medication became missing from the facility for 1 of 3 residents reviewed (Resident #6). The facility reported a census of 86 residents.Findings include:The facility corrected the deficiency per past noncompliance through the following actions:All nurses and certified medication assistants were re-educated on the administration and disposal of controlled medications on [DATE]. Audits initiated on [DATE] of all narcotics delivered from [DATE] - [DATE] on all current, discharged and deceased residents. No further discrepancies found. Resident #6's prescription was replaced by the facility at the cost of the faciity. The Minimum Data Set (MDS) dated [DATE] revealed Resident #6 had a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment. The MDS documented Resident #6 received a scheduled and as needed pain medication. The MDS further documented Resident #6 had a diagnosis of intervertebral disk degeneration, lumbar region with discogenic back pain and lower extremity pain.Review of Resident #6's Medication Administration Records (MAR) documented a physician's order for Oxycodone / Acetaminophen 10/325 mg take 1 tablet by mouth twice daily for spondylosis, lumbar region with a start date of [DATE].Review of Resident #6's document titled, Individual Patient's Narcotic Record documented oxycodone tablet 10-325 take 1 tablet by mouth twice daily with a quantity of 30 received on [DATE] at 8:00 PM signed by Staff A, Certified Nurse Assistant (CNA) / Certified Medication Assistant (CMA) and Staff B, Registered Nurse (RN) for end of shift count signatures, on [DATE] at 6:00 AM count of 30 by Staff B and Staff C, CNA/CMA for end of shift count signatures, and on [DATE] at 2:00 PM count of 30 by Staff C only.Review of document dated [DATE] titled, Proof of Delivery documented Resident #6 had two prescriptions for oxycodone / acetaminophen 10-325 mg delivered with a count of 30 for each prescription signed as received by Staff D, Licensed Practical Nurse (LPN).On [DATE] at 12:45 PM Staff A stated on [DATE] she received 2 narcotics cards for Resident #6. Staff A explained the medication was oxycodone / acetaminophen. Staff A said Staff D was the nurse that night and she received the medications from the pharmacy. Staff A stated she rubberbanded the 2 cards of oxycodone / acetaminophen together in the cart. Staff A stated the oncoming nurse was Staff B and she counted the narcotics with her at 10:00 PM on [DATE] when she came in. Staff A stated at that time there were 60 tablets total with 30 on each prescription card. Staff A explained the narcotics count sheet for the medication had the pharmacy sticker on it. Staff A stated she came back in at 6:00 AM and worked the cart on Sunrise hall. Staff A stated before she left for the day at 2:00 PM she was asked about the narcotics sheet. Staff A stated she was asked if there was a sticker on it. Staff A stated there was a sticker in place and there were 60 when she signed it in. Staff A stated she then received a phone call from the Assistant Director of Nursing (ADON) and the Administrator asking her about her signature and she stated it was not her signature on the count sheet for Resident #6's oxycodone / acetaminophen either. Staff A explained the narcotics were missing from the Skyline hall. Staff A said Staff C was the CMA on the medication cart [DATE] on Skyline hall. Staff A stated when she was the CMA on the medication cart she would count the narcotics with the oncoming nurse. Staff A stated usually on (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skyline hall on overnight to day shift it is a nurse to medication aide or medication aide to nurse. Staff A explained Staff B would have counted with Staff C. Staff A said the evening shift of [DATE] was Staff E, CNA/CMA and that was when she was called into the office. Staff A stated she did not know what had happened to the medications. Staff A said she told the ADON if there was a need for a new sheet she was working then she should have been called over to sign the sheet herself. On [DATE] at 3:07 PM Staff E stated she was working on [DATE] and [DATE]. Stated she was working on [DATE] and reported the missing narcotics for Resident #6. Staff E stated she completed the count with someone but did not remember who it was. Staff E stated the other CMA signed the narcotics sheet but she refused to sign it because it was not correct. Staff E explained the CMA that she counted the narcotic medications with said the count was correct and left to go home. Staff E stated she then went down to the ADON's office and told her the count was not right, it was off by a whole card of 30 narcotics. Staff E stated it was a twice a day medication and the box at the top of the sheet was not there. Staff E said it was hand written and not a sticker like normal. Staff E stated she asked why it was hand written. Staff E stated the CMA stated she spilled a liquid medication on it and had to write another one. Staff E explained the CMA that worked before her had written all the signatures on the narcotic sheet for all the staff. Staff E stated the ADON asked how she knew the count was off . Staff E stated the paperwork was different and the original paper said 60 as a count and there was not 60. Staff E stated the medication was twice a day and there should have been 2 medication cards. Staff E stated if the narcotic medication was twice a day or three times a day the pharmacy sends a 30 day supply. Staff E stated the ADON then checked all of the medication carts in the building and checked them again. Staff E stated they then checked the trash cans and the shred bins. Staff E stated it had been 24 hours and none of the trash had been picked up yet. Staff E explained the staff could not find the original count sheet or the medication cards. Staff E stated the CMA stated she had thrown the count sheet in the trash. Staff E stated the Administrator climbed through the dumpster and found nothing for the missing narcotics. Staff E stated she thought someone had to have taken the medications somewhere. Staff E stated the paperwork was gone that was why she knew it was staff that had taken the medications. Staff E stated when the count was completed one person looked at the narcotics book and one looked at the narcotic medication card. Staff E stated that was to make sure things are correct. Staff E stated if there was a CMA then she would count with a CMA. On [DATE] at 3:10 PM Staff B, RN stated she worked at the facility last in January working for an agency company. Staff B explained she worked the evening of [DATE]. Staff B said she counted the narcotic medications with Staff A that evening when she came in at 10:00 PM. Staff B stated Resident #6 had two cards of oxycodone / tylenol with 30 tablets. Staff B stated she did not know what the facility usually did but she said why not count both together on one sheet. Staff B stated there were 60 tablets of oxycodone / APAP total. Staff B stated they were counted all together on one narcotics count sheet. Staff B stated the sheet that came with the card had a sticker from the pharmacy with the name of the medication, resident's name and dose of the medication. Staff B stated in the morning on [DATE] she counted all the narcotics and then Staff C double checked the narcotics. Staff B explained the count was completed right there in the open area at the medication cart. Staff B stated there were no concerns and count was correct. Staff B stated Staff C looked at each narcotic medication card but did not count out loud. Staff B stated she was called later that day from the facility. Staff B stated the facility stated oxycodone / tylenol card and count sheet for Resident #6 were missing. Staff B stated she explained that both were there for Resident #6 when she left. Staff B stated she had destroyed narcotic medications once or twice but it was always with 2 nurses. On [DATE] at 12:15 PM Staff F, Registered Nurse (RN) stated she had worked together with Staff C maybe 2 or 3 times. Staff F acknowledged she worked the morning of [DATE]. Staff F explained on that day it was just a normal shift. Staff F stated Staff C went to lunch and returned from lunch. Staff F said at shift switch over time Staff C was filling out a narcotic count sheet. Staff F said Staff C said the narcotic count sheet was not filled out properly. Staff F explained Staff C had (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said she had spilled a liquid medication on the narcotic count sheet for Resident #6's oxycodone / tylenol medication's previous sheet. Staff F stated she could not remember if Staff C talked to her about an as needed medication that needed to be checked off. Staff F stated Staff C never told her that she was going to destroy any medication. Staff F stated there was a possible medication change that morning. Staff F stated a resident had a medication dosage change and that was why she could not click it off the effectiveness of the medication in the EHR system. Staff F stated the order in the EHR system was probably changed or discontinued and you could not check off the effectiveness for that medication afterwards. Staff F stated she did not remember the medication. Staff F stated when a CMA destroyed a narcotic there would have to be a second signature of the second staff present when the medication was destroyed. Staff F stated now the policy was management was the only person that could destroy a narcotic. Staff F stated it was not commonplace for anyone to destroy a narcotic without a nurse present. Staff F stated Staff C would have counted the narcotics with the previous nurse on the overnight shift, Staff B. On [DATE] at 11:56 AM Staff C said the narcotic medication oxycodone / acetaminophen was not missing and she accidentally destroyed them. Staff C stated [DATE] was like every other day. Staff C stated she did not count the narcotics with Staff B and would have noticed the medication cards were out of order if she did count them. Staff C stated before lunch there was a resident that had an as needed medication and when she tried to click the effectiveness off the EHR / MAR it would not let her do it. Staff C explained the EHR said the medication had been discontinued and she told Staff F, Registered Nurse (RN) that she was going to get rid of it. Staff C said the medications were out of order and she destroyed the wrong medication that day. Staff C stated it was close to lunch time and she was busy and did not tell Staff F that the medication had been discontinued. Staff C stated she forgot about destroying the medication. Staff C explained some time between lunch and 1:00 PM on [DATE] Staff E started doing count. Staff C said she was not doing count with Staff E and that was when she realized she did not tell Staff F. Staff C stated she was prideful and did not say anything until she had left. Staff C explained she told the ADON at that time what had happened. Staff C stated destroying narcotic medications without a nurse or second CMA present happened all the time. Staff C stated she had seen other nurses do the count sheet the same so she did the count sheet over. Staff C stated she did not have to write any signatures for anyone else. Staff C stated she did not [NAME] anyone's signatures on the oxycodone / acetaminophen count sheet she wrote on. Staff C explained she did not recall forging any signature. Staff C stated the new count sheet was a whole new paper. Staff C stated when she destroyed the narcotic she threw the bubble pack away in the garbage on her medication cart and put the top of the medication card with the resident's name in the shred bin. Staff C stated she did not remember if there were any required signatures for the destruction of the narcotic. Staff C said Resident #6's medication was destroyed. Staff C stated if she would have completed the count that morning with Staff B she would have noticed the medication cards were not together. Staff C stated she had worked as the main medication aide on skyline hall on [DATE] and that was the hall she normally passed medications on. Staff C stated she was aware the medication was twice a day, Resident #6 had 2 cards of oxycodone / tylenol, when new cards were brought in there might be 3 and the 2 were rubberbanded together. Staff C stated she did not remember if there were numbers written on the medication cards but the pharmacy always sent 2 cards for Resident #6 of the oxycodone / tylenol. Staff C acknowledged she did not do the 3 checks before destroying the medication. Staff C stated the 3 checks were right resident, right medication and right dose. Staff C explained she did not remember the medication that was popping up that required effectiveness that she thought originally was discontinued or the residents name. Staff C stated she did not know how that had resolved on the computer. Staff C said the as needed medication must have been given on the overnight or the PM shift. Staff C said upon further inspection she found out the dose had changed and had not been discontinued. Staff C stated she did not tell Staff F of her mistake. Staff C said she pulled the narcotic card out and put the tablets in the drug buster right next to where the printer would be in the (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication room. Staff C stated she ripped off the top of the narcotic medication card and put it in the shred bin. Staff C stated she took the trash out right before lunch and if the Administrator, Director of Nursing (DON) or the ADON would have gone through the garbage sacks they would have found the count sheet. Staff C stated it was not uncommon for medication aides to destroy narcotics by themselves. Staff C explained she did not look at the name on the medication card and just destroyed the medication. Staff C stated the facility did not take her statement and she did not hear anything until she was terminated. On [DATE] at 12:38 PM the DON stated when narcotics were destroyed 2 nursing staff must be present. The DON stated the 2 staff will remove the medications, count the medication and dump them in the drug buster container. The DON stated the drug buster was kept in the medication room. The DON stated there is not a drug buster on the medication carts. The DON explained on [DATE] all the carts were checked and the ADON and her went back through all the medication cards to ensure the medication was not anywhere. The DON stated then the Administrator went through the trash can and the dumpster looking for any of the medication cards or the medication count sheet for Resident #6's oxycodone / acetaminophen. The DON explained Staff C said she had spilled liquid medication on Resident #6's oxycodone / acetaminophen count sheet, had falsified the signatures, then came back and said she destroyed the medication. The DON stated Staff C explained she had done by herself before which the facility had determined that was not true. The DON stated they searched the recycle bin and the top of the medication card was not anywhere in there. The DON said the medication card was not in the trash either. The DON explained Staff C had switched the count from 60 to 30 and that was why Staff E that had come on the shift noticed it. The DON stated Staff E was the CMA that found the difference in the medication count. The DON stated Staff E went to the ADON, reported the count difference, the ADON went to the narcotics drawer, called the DON, asked for more direction and asked when the oxycodone / acetaminophen was delivered for Resident #6. The DON stated the oxycodone / acetaminophen for Resident #6 had to have been removed from the facility. The DON stated she expected the medication would have been present with the appropriate quantity. On [DATE] at 12:40 PM the Administrator stated Resident #6's oxycodone / acetaminophen prescription was replaced by the facility at the cost of the facility. The Administrator stated Staff C was suspended immediately upon discovery of the discrepancy and later terminated after the incident was investigated. The Administrator stated she had searched all garbage at the facility including the dumpster. The Administrator stated the medication, the medication card and the medication countsheet for Resident #6's oxycodone / acetaminophen was never found. The Administrator stated the medication had to have been removed from the facility.Review of policy provided by the facility dated [DATE] titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy documented all residents had the right to be free of 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. Dependent adult abuse was defined under Iowa law. Any of the following as a result of the willful misconduct or gross negligence or reckless acts or omissions of a caretaker, taking into account the totality of circumstances. Exploitation of a dependent adult. Exploitation means a caretaker knowingly obtains, uses, endeavors to obtain to use or who misappropriates a dependent adult's funds, assets, medications, or property with the intent to temporarily or permanently deprive a dependent adult of the use, benefit or possession of the funds, assets, medication or property for the benefit of someone other than the dependent adult.