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	10/31/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49628 Based on clinical record review and staff interviews the facility to notify the Long-Term Care (LTC) Ombudsman of a transfer to the hospital for 1 of 6 residents reviewed (Resident #26). The facility reported a census of 85 residents. Findings include: Resident #26's Clinical Census reflected she had an unpaid hospital leave from 6/2/24 - 6/10/24. Review of the facility document, Notice of Transfer Form to LTC Ombudsman, for the month of Jun 2024 lacked notice of Resident #26's hospitalization . During an interview on 10/29/24 at 2:25 PM the Director of Nursing (DON) stated Social Services typically handled the bed holds and notification to the LTC Ombudsman. She added the document would be in the chart. During an interview on 10/30/24 at 10:55 AM the Social Services Director stated Resident #26 didn't have a signed bed hold or notification to the LTC Ombudsman when she admitted to the hospital. During an interview on 10/30/24 at 11:00 AM the Administrator acknowledged the facility didn't do a bed hold or notify the LTC Ombudsman for Resident #26's hospitalization starting on 6/2/24.

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on record review, staff interviews, and policy review the facility failed to offer the resident, the Resident's Representative, and/or the Power of Attorney (POA) of a bed hold for 1 of 6 residents reviewed (Resident #26). The facility reported a census of 85 residents. Findings include: Resident #26's Clinical Census reflected she had an unpaid hospital leave from 6/2/24 - 6/10/24. Resident #26's electronic and paper clinical record lacked a bed hold for the hospitalization from [DATE] - 6/10/24. During an interview on 10/29/24 at 2:25 PM the Director of Nursing (DON) stated Social Services typically handled the bed holds and notification to the LTC Ombudsman. She added the document would be in the chart. During an interview on 10/30/24 at 10:55 AM the Social Services Director stated Resident #26 didn't have a signed bed hold or notification to the LTC Ombudsman when she admitted to the hospital. During an interview on 10/30/24 at 11:00 AM the Administrator acknowledged the facility didn't do a bed hold or notify the LTC Ombudsman for Resident #26's hospitalization starting on 6/2/24. The facility document, Bed Hold Policy, dated 3/9/19 instructed when a resident transferred to a hospital or goes on therapeutic leave, the facility will provide the Bed Hold Notice form to the resident or the resident's representative.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clinical record review and staff interview, the facility failed to refer 2 residents with a negative Level I result for the Preadmission Screening and Resident Review (PASRR), who later identified with a newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state designated authority for a Level II PASRR evaluation and determination for 2 out of 2 residents reviewed (Residents #16 and #36) for PASRR requirements. The facility reported a census of 85 residents. Finding include: 1. Resident #16's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. The MDS included a diagnosis of schizophrenia. The Level 1 Form Pre Admission Screening and Resident Review dated 8/20/20 lacked a diagnosis of schizophrenia under the diagnosis of major mental illness portion of the screening. The Doctor's Orders and Progress Notes dated 8/12/20 listed a diagnosis of schizophrenia with delusions. On 10/29/24 at 3:03 PM the Administrator stated she expected when they submitted the PASRR it included the diagnosis of schizophrenia at that time. The Administrator stated they should have caught the diagnosis of schizophrenia since 2020 when diagnosed . On 10/30/24 at 2:00 PM the Administrator reported the facility didn't have a policy for related to PASRR. The Administrator added they followed the Federal regulations. 49628 2. Resident #36's MDS assessment dated [DATE] identified a Staff Assessment for Mental Status indicating they had moderately impaired cognitive skills for daily decision making. The MDS included diagnoses of anxiety disorder, psychotic disorder, and Parkinsonism. The Preadmission Screening and Resident Review (PASRR) Level I Screen Outcome, dated 11/6/20 listed a summary of findings as Resident #36 didn't show evidence of a serious mental illness or an intellectual or developmental disability(IDD) that required PASRR intervention. The document provided Resident #36 had a current diagnosis of anxiety disorder and received fluoxetine (antidepressant) 20 milligrams (mg) per (/) day. The document instructed to submit a new screen if changes occur or new information refutes the findings. Resident #36's Medical Diagnoses included the following diagnoses: a. 10/1/23: Parkinson's Disease. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. 10/1/22: unspecified dementia, unspecified severity, with other behavioral disturbance. c. 7/4/21: Unspecified psychosis not due to a substance or known physiological condition d. 11/10/20: Anxiety disorder The medical diagnosis of unspecified psychosis not due to a substance or known physiological condition occurred during Resident #36's stay in the facility. The Physician 60 Day Recertification dated 7/6/21 included an order for quetiapine (Seroquel, antipsychotic) 25 mg at bedtime with an original date of 5/6/21. The Physician 60 Day Recertification dated 11/8/21 revealed a diagnosis of unspecified psychosis not due to a substance or known physiological condition. The document included the following medication orders: a. Fluoxetine Cap 40 mg for anxiety disorder (indications for use behavior management) b. Quetiapine Tab 25 mg three times a day for unspecified dementia with behavioral disturbance (indications for use: psych management). The Mental Health Clinic Note dated 10/10/21 reflected Resident #36 started psychiatric services due concerns with behavioral issues including depression, anxiety, nutrition, confusion, resistance to care, and irritability. The document indicated the provider prescribed her psychiatric medications of Prozac (antidepressant) 40 mg daily and Seroquel (antipsychotic) 25 mg three times a day. The treatment plan instructed to follow-up in plus or minus (+/-) 4 weeks or as clinically indicated. The Mental Health Authorization signed by Resident #36's Power of Attorney (POA) on 10/20/23 indicated Resident #36 would receive mental health services. During a continuous interview on 10/29/24 at 2:30 PM the Director of Nursing (DON) stated verified Resident #36's most recent PASRR as the 11/6/20 date. The DON acknowledged the addition on 7/4/21 of the diagnosis of unspecified psychosis not due to a substance or known physiological condition should had a new PASRR completed to reflect the additional diagnosis. The Social Services Director confirmed Resident #36 didn't have a newer PASRR than the facility provided document dated 11/6/20. In interviews on 10/30/24 at 10:50 AM and 11:55 AM the Administrator stated the facility submitted a new PASRR for Resident #36. They acknowledged Resident #36's clinical record included the diagnosis of unspecified psychosis not due to a substance or known physiological condition on 7/4/21. Resident #36 didn't have a new PASRR completed at that time. The facility didn't have a PASRR policy but stated they followed the Federal regulations.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on video review, electronic health record (EHR) review, document review, resident, and staff interviews the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 4 of 24 resident reviewed (Residents #10, #22, #54 and #289). The facility reported a census of 85 residents. Findings include: 1. Resident #54's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS listed Resident #54 as frequently incontinent of urine and of bowel. On 10/28/24 at 11:55 AM Resident #54 stated one day last week on 10/20/24, 10/21/24, or 10/22/24 it took until 8:00 AM before they answered her call light. Resident #54 reported she wanted to get up, use the restroom, and go to breakfast that day. Resident #54 explained the facility had call-ins that day. Resident #54 added it could take up to an hour for them to answer the call light, and has in the last 2 weeks. The Alarm Response Report for dates 9/29/24 10/29/24 reflected call lights with response times longer than 15 minutes as: a. 9/29/24 call light turned on at 6:36 AM and cleared at 7:09 AM for a total of 33 minutes. b. 9/30/24 call light turned on at 6:35 AM and cleared at 7:09 AM for a total of 34 minutes. c. 10/1/24 call light turned on at 6:55 AM and cleared at 7:12 AM for a total of 16 minutes. d. 10/4/24 call light turned on at 6:35 AM and cleared at 6:52 AM for a total of 17 minutes. e. 10/6/24 call light turned on at 6:33 AM and cleared at 7:04 AM for a total of 31 minutes. f. 10/8/24 call light turned on at 6:23 AM and cleared at 7:10 AM for a total of 47 minutes. g. 10/8/24 call light turned on at 9:53 AM and cleared at 10:18 AM for a total of 24 minutes. h. 10/10/24 call light turned on at 3:04 PM and cleared at 3:26 AM for a total of 22 minutes. i. 10/12/24 call light turned on at 9:54 AM and cleared at 10:12 AM for a total of 17 minutes. j. 10/13/24 call light turned on at 6:26 PM and cleared at 6:44 PM for a total of 18 minutes. k. 10/18/24 call light turned on at 9:54 AM and cleared at 10:11 AM for a total of 16 minutes. l. 10/19/24 call light turned on at 6:22 AM and cleared at 7:08 AM for a total of 45 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	m. 10/20/24 call light turned on at 6:24 AM and cleared at 7:10 AM for a total of 46 minutes. n. 10/22/24 call light turned on at 6:23 AM and cleared at 7:06 AM for a total of 42 minutes. o. 10/26/24 call light turned on at 6:25 AM and cleared at 6:53 AM for a total of 27 minutes. p. 10/27/24 call light turned on at 6:36 AM and cleared at 6:54 AM for a total of 18 minutes. q. 10/28/24 call light turned on at 6:25 AM and cleared at 6:43 AM for a total of 18 minutes. On 10/29/24 at 2:27 PM Staff D, Certified Nursing Assistant (CNA), explained the facility had a chime that alerted the staff when a resident turned on a call light. Staff D stated they had a screen hanging from the ceiling that showed what room turned on the call light. Staff D stated sometimes it took longer than 15 minutes to answer the call lights. Staff D stated it frequently took longer on Sunrise hall because they have more 2-person lifts. Staff D stated any response longer than 10 minutes is too long. Staff D stated she thought the facility's expected call light response times as between 10- and 15-minutes. On 10/29/24 at 2:54 PM the Administrator acknowledged the call light concern. The Administrator stated the staff sometimes forgot to shut off the call light. The Administrator stated the management had monitored the call light length. The Administrator acknowledged call lights lasted longer than 15 minutes. The Administrator stated call light response should be 15 minutes or less. On 10/30/24 at 2:00 PM the Administrator stated the facility didn't have a policy for call light response. The Administrator stated the facility followed federal regulations. 44420 2. Resident #22's MDS assessment dated [DATE] identified a BIMS score of 15, indicating no cognitive impairment. The MDS listed Resident #22 as dependent or required partial assistance for toileting hygiene, bathing, and lower body dressing. In addition, Resident #22 required supervision or touching assistance for personal hygiene. The MDS included diagnoses of polio (a viral infection that can lead to partial or full paralysis), lack of coordination, muscle weakness, abnormalities of gait and mobility. In an interview on 10/28/24 at 12:34 PM, Resident #22 reported it took staff 45 minutes to answer his call light that morning. Resident #22 stated, they didn't have enough help. Resident #22 explained it took staff 20 to 30 minutes to answer the call light. Resident #22 added, he urinated in his chair because it took so long. It pissed him off when he had to urinate in his own chair. The Care Plan Focus revised 2/13/22 indicated Resident #22 had a risk for injury from falls related to diagnoses of post-polio syndrome, psychotropic medications, and impaired mobility. The Interventions instructed Resident #22 had a sign in his room as a reminder to use his call light. Resident #22's Call Light log for dates from 10/7/24 through 10/28/24 reflected response times greater than 15 minutes: a. On 10/7/24 at 9:56 AM the call light response time took over 29 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 10/10/24 at 6:24 PM the call light response time took over 17 minutes c. On 10/11/24 at 11:38 PM the call light response time took over 23 minutes. d. On 10/12/24 at 8:49 AM the call light response time took over 19 minutes. e. On 10/17/24 at 9:01 AM the call light response time took over 18 minutes. f. On 10/16/24 at 7:36 AM the call light response time took over 20 minutes. g. On 10/28/24 at 7:26 AM the call light response time took over 42 minutes. In an interview on 10/28/24 at 1:54 PM, Staff A, Registered Nurse (RN), reported the facility answered the call lights after 15 minutes when a shift didn't have enough staff. Staff A reported the facility had 2 to 3 times a week they didn't have enough staff. In an interview on 10/28/24 at 2:15 PM, Staff B, CNA, reported they didn't answer the call lights within 15 minutes when they had a shift short staffed. Staff B stated, when they are short staffed they can't answer all the call lights within 15 minutes, especially around meal times. In an interview on 10/28/24 at 2:22 PM, Staff C, CNA, said when they are short staffed they can't answer the call lights within 15 minutes, or properly toilet residents every two to three hours. They have to rush routine cares and staff get burned out. 49628 3. Resident #289's MDS assessment dated [DATE] listed as in progress reflected an admitted as 10/24/24. The completed portion identified a BIMS score of 13, indicating no cognitive impairment. Resident #289 required substantial/maximal assistance for toileting hygiene, bathing, or lower body dressing. In addition, Resident #289 required substantial/maximal assistance for sit to stand movements, and toilet/bed/chair transfers. The MDS portion related to medical diagnosis remained incomplete. Resident #289 Medical Diagnoses included a diagnosis of unspecified fracture of the upper end of the left humerus (upper arm). On 10/28/24 at 11:50 AM Resident #289 reported it sometimes took a long time, over 15 minutes, for the staff to answer call lights. The resident stated it happened a couple of times since coming into the facility the previous week. Resident #289's Baseline Care Plan, dated 10/24/24, indicated they required 1 assist for transfers, continent of bowel, and bladder. Resident #289's Call Light Log during the one week look back period of 10/24/24 through 10/29/24 reflected the following times greater than 15 minutes: a. On 10/26/24 at 12:31 PM the call light response time took over 19 minutes. b. On 10/27/24 at 6:07 PM the call light response time took over 21 minutes (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #10's MDS assessment dated [DATE] identified a BIMS of 15, indicating no cognitive impairment. The MDS listed Resident #10 as dependent or required partial assistance for toileting hygiene, bathing, and lower body dressing. In addition, Resident #10 required partial or moderate assistance for sit to stand movements, chair, bed, and toilet transfers. The MDS included diagnoses of end stage renal (kidney) disease, muscle weakness, and pulmonary hypertension (a type of high blood pressure that affected the lungs and the right side of the heart). The Care Plan Focus revised 3/13/23 indicated Resident #10 had a risk for injury from falls related to a diagnosis of end stage renal disease. The Interventions revised 10/7/24 directed to transfer with full body lift with 2-person assist. On 10/28/24 at 12:43 PM observed Resident #10 seated in a wheelchair with the call light attached to a lamp behind them, out of their reach. Resident #10 stated she didn't have a way to contact staff, and wanted to get out of her wheelchair into her recliner. Resident #10 reported the staff take a while to answer her call light. Observed an unidentified CNA walk past her room without looking in at Resident #10. At 12:55 PM witnessed the Activities Director enter Resident #10's room to deliver mail, and heard her ask for the call light as she wanted to get into her recliner and had no way to get help. The Activity Director gave Resident #10 her call light and went to get CNA assistance. Resident #10's Call Light log during the three weeks look back period of 10/7/24 through 10/28/24 reflected call light response times greater than 15 minutes: a. On 10/8/24 at 7:25 AM the call light response time took over 28 minutes. b. On 10/8/24 at 10:53 AM the call light response time took over 46 minutes. c. On 10/8/24 at 11:25 AM the call light response time took over 27 minutes. d. On 10/8/24 at 12:04 PM the call light response time took over 17 minutes. e. On 10/8/24 at 1:38 PM the call light response time took over 26 minutes. f. On 10/10/24 at 5:58 AM the call light response time took over 25 minutes. g. On 10/10/24 at 6:50 AM the call light response time took over 24 minutes. h. On 10/10/24 at 11:20 AM the call light response time took over 26 minutes. i. On 10/10/24 at 1:22 PM the call light response time took over 20 minutes. j. On 10/12/24 at 3:59 AM the call light response time took over 28 minutes. k. On 10/12/24 at 7:16 PM the call light response time took over 27 minutes. l. On 10/12/24 at 6:41 PM the call light response time took over 31 minutes. m. On 10/13/24 at 7:59 PM the call light response time took over 19 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	n. On 10/14/24 at 11:15 PM the call light response time took over 28 minutes. o. On 10/21/24 at 4:36 PM the call light response time took over 20 minutes. p. On 10/22/24 at 4:52 PM the call light response time took over 19 minutes. q. On 10/22/24 at 5:47 PM the call light response time took over 59 minutes. r. On 10/26/24 at 10:11 AM the call light response time took over 22 minutes. s. On 10/28/24 at 6:04 PM the call light response time took over 18 minutes. t. On 10/6/24 at 8:36 AM the call light response time took over 17 minutes. On 10/30/24 at 10:30 AM, Staff F, CNA, stated call lights might run longer than 15 minutes when residents are having behaviors or cares that require longer times. Staff F added one hall had several residents with behaviors which take increased time. On 10/30/24 at 10:35 AM, Staff G, CNA, stated call lights may be longer when residents turn their call light back on immediately after staff answer their call light, and they have to wait while staff attend to other resident(s) who had been waiting. Staff stated some residents have behaviors which may cause a staff member to remain in a room to meet the resident needs, leading to call lights for other residents to run long. On 10/29/24 at 2:30 PM the Director of Nursing (DON) stated they expected the staff to answer call lights within 15 minutes. The DON stated the facility completed morning reviews of call lights, and then asks staff about the reason for the extended call light response times. The DON reported the facility started trialing the use of walkie talkies to enhance communication.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49628 Based on the facility staff report and interviews the facility failed to provide Registered Nurse (RN) coverage for at least 8 consecutive hours a day for 7 days a week. The facility census was 85. Findings include: The September 2024 and October 2024 Nurse Schedule reflected the scheduled RN called to quit on 9/21/22, then walked out on 9/22/24. The document didn't include any other scheduled RNs on those dates. In an interview on 10/30/24 at 2:15 PM the Staff Coordinator stated on 9/21/24 and 9/22/24 she didn't have the on call phone, but knew about the situation. The Staff Coordinator stated the scheduled RN called in sick on 9/21/24 after being at work less than 30 minutes. On 9/22/24 the RN walked into the facility, looked at the schedule, and walked out. The Staff Coordinator stated they didn't fill the position with a RN for the empty shifts. The Staff Coordinator reported during the weekends they had limited RNs on the schedule/available, during the work week the acting DON may cover the RN position if necessary. In an interview on 10/30/24 at 2:25 PM the Administrator with the Nurse Consultant present acknowledged they didn't have RN coverage on 9/21/24 and 9/22/24. The Administrator stated the scheduled RN called in on 9/21/24 and walked in 9/22/24, looked at the schedule, and walked out. The Administrator said she didn't know about the call in on 9/21/24, but knew on 9/22/24 of the staff walking out. The Administrator stated the facility followed regulations for staffing.

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on clinical record review and staff interview the facility failed to address dementia care for 1 out of 3 residents reviewed (Resident #1). The facility reported a census of 85 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. The MDS included diagnoses of non Alzheimer's dementia, stroke, seizure disorder (epilepsy), dementia mild, without behavioral, psychotic or mood disturbance, and anxiety. Resident #1's Care Plan revised 10/21/24 lacked information regarding dementia care. The Comprehensive Care Plan policy revised 7/18/22 instructed care, treatment and services shall be planned to ensure they are individualized to the resident's needs. The facility shall provide an individualized, interdisciplinary plan of care for all residents that shall be appropriate to the resident's needs, strengths, results of diagnostic testing, limitations and goals. Results of the assessment shall be used to develop, review, and revise the resident's comprehensive plan of care. A comprehensive Care Plan for each resident shall be developed that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The Care Plan shall describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being as required. In an interview on 10/29/24 at 01:43 PM, the Director of Nursing (DON) reported the facility should have addressed Resident #1's dementia on the Care Plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165524	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER: Bethany Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49628 Based on observation, staff interview, and facility policy review the facility failed to prepare, serve and distribute food in accordance with professional standards. The facility reported a census of 85 residents. Findings include: During an observation on 10/28/24 at 9:55 AM Staff H, Cook, completed modification of the entree to mechanical soft consistency. Staff H obtained cooked turkey measured prior to the modification. Without performing hand hygiene, Staff H donned (applied) a glove to the right hand. They said they would use the gloved hand for placement of the turkey in the processor while the left hand would run the food processor. Staff H picked up the turkey with the gloved hand and placed it in the food processor. Staff H then placed their gloved hand over top of the processor, while the left hand managed the controls of the processor. Staff H used the non gloved hand to pour the contents into the measuring cup while the gloved hand used a scraper and moved the contents into the measuring cup. Once completed with the scraper Staff H used their gloved hand to compact the turkey in the measuring cup to obtain the correct measurement. They poured the turkey into a warming pan. Staff H proceeded to repeat the process for the mechanical soft turkey for the second dining room. Staff H picked up the turkey from the premeasured container for processing with the gloved hand and placed it in the processor. Staff H continued to use the gloved hand to cover the processor, use a scraper and compacted the food in the measuring cup. When completed Staff H removed the glove and threw it away. Without completing hand hygiene, they covered the food and placed it in the steam oven. On 10/28/24 at 11:28 AM observed Staff H prepare the noon meal including temperatures and preparation of buttered bread. Staff H removed food items from the steam oven for distribution to the kitchenette and main steam table. Observed Staff H on 3 of 8 instances of stabbing the thermometer through the aluminum foil covering creating large holes in the top. For the remaining 5 instances Staff H uncovered the food for temperatures and then recovered the food. During the preparation of buttered bread, Staff H, donned a single glove on the left hand, opened the package of bread, obtained a slice of bread, used the ungloved hand to apply butter to the slice of bread while the gloved hand held the bread, and then used the gloved hand to place the bread on a serving tray. Staff H repeated the process several times using the gloved hand to touch the bread wrapper and bread. Observed serving tongs beside the bread. Staff H did not wash their hands prior to glove application, but did wash after they removed their glove. In an interview on 10/30/24 at 10:45 AM the Dining Services Manager stated staff shouldn't touch other items when using a gloved hand for food management. The Dining Services Manager explained using tongs would be the best option for touching food items. The Dining Services Manager stated staff should complete hand hygiene immediately after removing gloves. The Dietary Policies and Procedures related to Use of Gloves dated April 2017 instructed to use gloves only for a single task and discard them when interruption occurs in the operation. (continued on next page)

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	165524	A. Building B. Wing	10/31/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Hand Hygiene CDC Guidelines facility document, updated 1/27/22 directed to complete hand hygiene immediately after glove removal.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, facility policy review, and staff interview the facility failed to provide appropriate infection prevention practices when administering medications, providing personal care, catheter care, and wound care for 3 of 4 residents reviewed (Residents #1, #22 and #58). The facility reported a census of 85 residents. Findings include: 1. Resident #22's MDS assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Resident #22's October 2024 Medication Administration Records (MAR) included physicians' orders for acetaminophen (pain medication), calcium (nutritional supplement), aspirin (used either for pain or blood clot prevention), multi vitamin (nutritional supplement), docusate sodium (stool softener), and vitamin D3 (nutritional supplement). On 10/30/24 at 8:03 AM witnessed Staff I, Registered Nurse (RN), removing the following medications for Resident #22: acetaminophen, calcium, aspirin, multi vitamin, docusate sodium, and vitamin D. He poured the medication from the stock bottles into his bare hands, and then placed the medications into the medication cup. Staff I then took medication to Resident #22, where he self-administered medications with sips of water. On 10/30/24 at 11:34 AM the Director of Nursing (DON) stated they would like to see the nurse pour the medications into the cap of the stock medication and then into the medication cup. The DON reported they expected medication poured into the cap of the stock medication or directly into the medication cup. The Medication Administration policy dated 6/30/23 instructed to wash hands with soap and water prior to beginning the medication pass. Ethanol / Alcohol (ETOH) waterless sanitizer is acceptable between residents and when dispensing medication into a medication cup. 2. Resident #58's Minimum Data Set (MDS) dated [DATE] identified a BIMS score of 15, indicating no cognitive impairment. The MDS reflected Resident #58 used a urinary indwelling catheter. On 10/30/24 at 6:23 AM observed Staff J, Certified Nursing Assistant (CNA), complete Resident #58's catheter care with the DON watching. Staff J knocked on the door, entered the room, completed hand hygiene and applied gloves. Staff J placed a barrier placed on the ground. Staff J cleansed the tip of the catheter with an alcohol wipe. Staff J applied a leg bag to the catheter tip. Without changing gloves or completing hand hygiene, Staff J completed peri cares for Resident #58. Staff J removed their gloves and applied new gloves. Staff J cleansed the catheter tubing with alcohol wipe. Staff J removed gloves, pulled up brief to resident #58's knees, applied a new glove to the right hand and pulled up Resident #58's brief the rest of the way. Staff J emptied Resident #58's catheter bag. Staff J applied a glove to the left hand, removed garbage, removed linen, left Resident #58's room. When Staff J entered the hallway, they disposed of the linen and garbage bags in a room across the hall, then they removed their gloves before completing hygiene. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 11:23 AM the DON reported the concerns she witnessed during the catheter cares as, no enhanced barrier precautions observed and Staff J didn't wear a gown. The DON acknowledged Staff J changed their gloves several times during the process and didn't do hand hygiene. The DON stated Staff J should have washed her hands prior to leaving Resident #58's room. The Transmission Based Precaution policy revised 6/5/24 directed to wear gowns whenever it is anticipated that clothing will have direct contact with the resident, potentially contaminated environmental surfaces, or equipment in close proximity to the resident. Gowns shall be donned upon entry into the room and removed with hand hygiene performed before leaving the resident care environment. The Hand Hygiene - Centers for Disease Control and Prevention (CDC) guidelines instructed healthcare personnel shall perform hand hygiene in accordance with the CDC recommendations. Healthcare personnel should use an alcohol based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids, or contaminated surfaces f. Immediately after glove removal. The CDC website titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug resistant Organisms (MDROs), updated 7/12/22 indicated recent changes included, additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug resistant organism (MDRO) colonization among residents in this setting. Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status). Expanded MDROs for which EBP applies. Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission. EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status and Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. 44420 3. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. The MDS included diagnoses of non Alzheimer's dementia, stroke, and seizure disorder (epilepsy). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's Skin and Wound Evaluation form dated 10/29/24 at 11:18 AM indicated they had a new Stage II partial thickness pressure ulcer with skin loss and exposed dermis to the coccyx area. On 10/30/24 at 9:06 AM witnessed Staff E, Licensed Practical Nurse (LPN), fail to perform hand hygiene, then apply gloves, unfasten Resident #1's brief, roll her on her side, remove the dressing to her coccyx area, open a skin prep packet, apply the skin prep around the pressure ulcer, discard the dressing then doff (remove) and discard their gloves. Without completing hand hygiene, Staff E opened the new dressing, obtained a marker from her pocket, labeled the dressing with the date then returned the marker back to her pocket. After removing her gloves, Staff E failed to perform hand hygiene, donned new gloves, applied a dressing to the coccyx area, assisted Resident #1 to roll on her back, fastened the brief, arranged blankets to cover her, and placed the call light on her lap. Staff E doffed and discarded gloves. Upon exiting the room, when inquired if Resident #1 should be on transmission-based precautions, Staff E replied, I don't think so. When reviewing the enhanced barrier precaution sign outside the resident's room Staff E stated, she should have worn a gown, sorry. When asked if they received enhanced barrier precaution education during orientation, Staff E responded, yes. In an interview on 10/29/24 at 1:43 PM, the DON explained staff should perform hand hygiene in between glove changes. The DON added they should use enhanced barrier precaution when changing a dressing on a wound with open skin.