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	10/02/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and policy review the facility failed to protect a resident from possible accidents and injuries for 1of 2 residents (Resident #38). The facility failed to provide adequate supervision to prevent elopement. On 7/20/25 between 4:30-4:40 PM the staff last saw Resident #38 standing by the front door where visitors were exiting. The door alarm sounded with Staff A responding to the alarm but he failed to locate Resident #38 and went back to his previous duties being unaware Resident #38 was outside. On 7/20/25 at approximately 5:00 PM Staff B looked out the dining room window and observed Resident #38 walking down the sidewalk past the facility, near the bridge over a creek, towards a high traffic 3 lane street with a speed limit of 35 miles per hour. The upcoming 3 lane street did not have a side walk on the side Resident #38 was walking towards. The State Agency informed the facility on 10/1/25 at 12:10 PM of the Immediate Jeopardy (IJ) that began on 7/20/25. The immediacy was removed on 7/21/25 when the facility completed the following: Door Alarm Response Policy (11/2/18) training.Missing Resident Policy (12/21/18) training. Elopement Response Drill training.The facility reported a census of 90 residents. Findings include: The Minimum Data Set (MDS) for Resident #38 dated 5/19/25 identified a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated severe cognitive impairment. The MDS documented diagnoses that included: hypertension, renal insufficiency, thyroid disorder and Alzheimer's Disease. Resident #1 was independent with transfers and ambulation. The document disclosed the resident exhibited wandering behavior 1-3 days during the assessment period and wore a wander/elopement alarm.The Care Plan dated 9/15/25 identified a wandering focus area dated 5/14/25 with staff interventions to ensure a pathway for following, monitoring for signs/symptoms of urinary tract infection and use of a Wander Guard (5/14/25). Additional interventions of escorting the resident to and from activities and staff to attend all activities to redirect the resident when necessary was added on 7/21/25. The document contained a focus area for impaired cognition related to Alzheimer's dated 5/27/25 with interventions of keeping a consistent routine and escorting to/from activities revised 9/10/25. The Wandering Risk assessment dated [DATE] revealed Resident #38 had a score of 10/16 indicating a high risk to wander. The areas identified on the document included the resident was ambulatory, had a history of wandering, and a medical diagnosis of dementia/cognitive impairment. The document contained comments that on the date of the entry the resident had been wandering the halls today, almost went through a set of doors that set off alarms. Resident is independent with ambulation and could be mistaken for a non-resident and make her way out of the building in certain circumstances. The Morse Fall Scale dated 5/12/25 revealed a score of 60/125 indicating a high risk for falling. The document identified the resident had fallen within the past 3 months, did not use ambulatory aids, impaired gait (uses furniture as assistance, keeps head down when walking) and overestimates or forgets own limitations. A facility investigation revealed on 7/20/25 Resident #38 was assisted to the main floor chapel (resident resided on the lower floor) for church with no staff members present. At 4:30 PM staff were paged to the chapel to assist residents back from church. Between 4:30 PM - 4:40 PM Staff L, Dietary Aide, observed the resident standing (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	by the front door and exit the building with visitors. Staff L stated an alarm did sound, but thought it was due to the visitors not entering the door code. Staff L stated she saw Staff A, CNA, respond to the door alarm. Staff A stated he only saw visitors outside. At approximately 4:45 PM Staff B, Certified Nurse Assistant (CNA), and Staff M, CNA, observed the resident walking along the sidewalk next to the facility parking lot. The staff were able to direct the resident back inside. The resident was wearing tennis shoes, scrub pants and a sweatshirt. All Wander Guards and door alarms were tested on [DATE]. A Progress Note entry dated 7/20/25 at 3:29 AM revealed the resident exhibited wandering behavior by walking the hallways on the first floor. Review of the weather on 7/20/25 using the World Weather revealed the temperature was +88ˆ with a real feel +100ˆ with 70% humidity.Review of the facility's Door Logs 6/30/25 to 10/1/25 revealed the following: The facility kept weekly logs of door checks.The facility consistently did not check doors on Sundays with the exception of 7/20/25 when the resident eloped and the doors were checked after the elopement.The door alarms were not checked on 7/19/25 the day prior to the elopement. The door alarms were not checked on 7/31/25 and 8/1/25. Observation on 10/1/25 revealed the facility was located on a residential east/west road on a hill with a speed limit of 25 MPH with a sidewalk that ran along the street in front of the facility. Going down the sidewalk along the street, one walked in front of the facility towards a 3 lane road with a speed limit of 35 MPH. Prior to reaching the road pedestrians were required to cross a bridge over a water flow way. The 3 lane road did not have a sidewalk closest to the facility. On 10/1/25 at 8:55 AM Staff B stated on 7/20/25 at approximately 5:00 PM she was in the lower dining room helping residents get ready for supper, when she looked out the window and saw Resident #38 walking down the sidewalk closest to the street near the fire hydrant and walking towards the 3 lane road. The staff stated she had Staff M go with her out the emergency door to get the resident. The staff stated the resident was near the fire hydrant when they reached her. The staff stated the resident indicated she was hungry and going for a walk to go to dinner. The staff stated they walked the resident back up the hill and came in the main door of the facility. Staff B stated she did not recall an alarm going off for the Wander Guard system prior to the resident's elopement. The staff stated when the Wander Guard alarm goes off it would go overhead on the call light system for the entire building for the specific door and what resident has exited. On 10/1/25 at 11:15 AM Staff E, Licensed Practical Nurse (LPN), stated on 7/20/25 he was working on the lower floor where the resident resided and was notified by staff of the elopement. The staff reported the church volunteers took the resident upstairs for the service and did not return her. The staff stated he did not observe the resident outside. Staff E stated he had checked her Wander Guard monitor and it was functioning. The staff stated the doors should lock when a resident was within 3 feet of the door and staff have to enter the door code and wander guard code to exit. On 10/1/25 at 11:35 AM Staff N along with the Receptionist demonstrated how the Wander Guard system worked with the main doors using a Wander Guard monitor. When the staff approached the main door with the monitor the doors would lock and the alarm wound sound. If the door code was entered with the monitor greater than 3 feet away the door would open without an alarm. If while the door was open and the monitor came closer to the door the alarm would sound and continue to sound until it was disarmed. On 10/1/25 at 12:35 PM Staff A stated he was working on the main floor on the date of the elopement. The staff stated the door alarms had been going off frequently that day due to visitors not entering the door code prior to exiting. The staff stated the alarm that went off when the resident eloped was the door alarm, not the Wander Guard alarm system. The staff stated he was not aware of a resident going out the door until much later. The staff stated when he came to the front door Staff L was attempting to shut the door alarm off. Staff A stated when the Wander Guard alarm went off a XD number code was revealed on the call light screen in the hallways indicating it was the Wander Guard. The staff stated when the alarm went off at the time of elopement the screen revealed R meaning right main door. On 10/2/25 at 8:00 AM the Administrator stated she would need the facility's policy regarding the frequency of doors to be checked. The Administrator expected staff to respond and follow the policies (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for door alarms and missing residents. The facility's Elopement Awareness Protocol, 7/21/22, provided door alarm checks and Wander Guard/Code alert checks were to be completed Monday through Saturday and Elopement Drills were to be completed routinely and documented. The facility's Door Alarm Response, 11/2/18, revealed staff were to immediately respond to the door that was sounding, walk outside, and scan the grounds to identify the source of the alarm. The document revealed if the source of the alarm was not identified, account for all residents and if a resident was unaccountable to initiate the missing resident policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, policy review, and staff interview the facility failed to provide appropriate infection prevention practices by not donning appropriate Personal Protective Equipment (PPE) or completing appropriate hand hygiene when personal care was completed and failed to provide appropriate infection prevention practices for waterborne pathogens for 5 of 24 residents reviewed (Resident #5, #8, #35, #89 and #77). The facility reported a census of 90 residents. Finding include:1. The Minimum Data Set (MDS) dated [DATE] for Resident #8 documented a Brief Interview for Mental Status (BIMS) of 14 indicating no cognitive impairment. The MDS indicated Resident #8 had a stage 4 pressure ulcer. Review of Resident #8's Medication Administration Record (MAR) documented a physician's order to cleanse coccyx wound with wound cleanser, apply collagen rope or collagen strip to wound tunnel, lightly pack, once every 3 days and as needed for wound care. Review of Resident #8's EHR titled, Orders documented physician's orders to cleanse coccyx wound with wound cleanser, apply collagen rope or collagen strip to wound tunnel, lightly pack, once every 3 days and as needed for wound care. On 10/2/25 at 7:41 AM an observation revealed a dressing change completed on Resident #8 by Staff G, Wound Care Nurse. Staff G completed hand hygiene, applied gloves, lowered Resident #8's head of bed to comfortable position, removed saturated dressing from coccyx, serosanguinous drainage noted on old dressing, cleansed area with wound cleanser, a dime sized area right on tail bone measures 1cm x 1cm x 3cm, Resident #8 acknowledged no pain at the area, Staff G did not change gloves or complete hand hygiene, collagen rope packed loosely into wound, dressing applied over wound, removed gloves, and completed hand hygiene. On 10/2/25 at 3:23 PM the DON stated the facility's expectation was hand hygiene would have been completed and gloves would have been changed after the wound was cleansed before applying a new treatment and dressing. 2. Resident #5's (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12/15 indicating mild cognitive impairment and had an indwelling catheter for bladder elimination. The MDS listed the resident as dependent on staff for toileting and transfers. Observation and interview on 10/01/2025 at 2:58 PM, Staff Q, CNA and Staff R, CNA in Resident #5's room without PPE gowns on. Staff R exited the room, and stated Staff Q and she had transferred the resident with a full body lift from the recliner to his bed. Staff R stated she did not wear a gown while transferring the resident. Staff Q remained in the resident's room, touching bed linens and placing the call light on the resident's blanket, without a gown on. Staff R stated the resident was on EBP for his catheter, and would wear gown/gloves only if emptying the urinal and when queried about the Contact Precautions sign outside the resident's room, Staff R stated staff should wear PPE for any contact with urine. EBP and Contact precautions sign posted outside the resident's room. Resident #5's Order Summary Report revealed an order for EBP due to foley catheter with order date 9/26/25. Resident #5's Care Plan revealed the following: (continued on next page)

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	165524	A. Building B. Wing	10/02/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Focus: Resident has need for Enhanced Barrier Precautions related to indwelling catheter, multi-drug resistant organism (MDRO) colonization. Date Initiated: 8/25/25. Interventions: Gown and gloves to be worn for high contact activities, have PPE available for staff near the entrance to the resident's room, maintain signage on/outside resident's door regarding precautions needed, required PPE, and high-contact resident care activities. Date Initiated: 8/25/25. Interview on 10/1/25 at 12:30 PM, Staff T, LPN and Infection Preventionist stated EBP required when residents have MDRO, catheter, port/ fistula (under skin access to veins), and chronic wounds and EBP would require PPE of gown, gloves, and if possibility of fluids would need goggles and mask for direct care. Staff T further stated if staff were doing oral care for a resident and the resident had a catheter, she wouldn't expect staff to wear PPE and if the resident has a catheter, only need to wear PPE when doing catheter care. Staff T stated with contact precautions staff need to wear a gown and gloves before entering the room, and was unaware if a resident on contact precautions can go out to the dining room. Interview on 10/1/25 at 12:53 PM, Staff S, CNA stated with contact precautions any contact with the resident requires gloves, gown, and mask and with EBP for UTI, something/infections that can spread and catheters staff would need to wear a gown and gloves with any direct contact with the resident. 3. Resident #77's MDS list revealed the resident was admitted on [DATE] and the MDS was was in progress. Resident #77's Order Summary Report identified an order for EBP due to foley catheter dated 9/26/25. Resident #77's Care Plan revealed the following: Focus: Resident has need for Enhanced Barrier Precautions related to indwelling catheter. Date Initiated: 9/24/25. Interventions: Gown and gloves to be worn for high contact activities, have PPE available for staff near the entrance to the resident's room, maintain signage on/outside resident's door regarding precautions needed, required PPE, and high-contact resident care activities. Date Initiated: 9/24/2025. Observation on 9/29/2025 at 3:12 PM, Resident #77 in bed and a staff member, without a gown or gloves, entered the resident's room, answered the call light, touching covers on the resident, raised the resident's head of bed, and provided the resident a drink. 4. Resident #35's MDS dated 9/825 revealed a BIMS score of 15/15 indicating normal cognition. The document revealed diagnoses of a pressure ulcer of the left (L) buttock, Stage 4 and encounter for surgical aftercare for surgery of the nervous system, other fracture. The document disclosed the resident had a Stage 4 Pressure Ulcer meaning full thickness tissue loss with exposed bone, tendon or muscle and often includes undermining and tunneling. Resident #35's Care Plan dated 9/24/25 revealed a focus area of actual pressure ulcer related to moisture and present upon admission (initiated 8/27/25 and updated 9/9/25). Interventions included assess ulcer, and stage, treatment as ordered, repositioning, and pressure reduction cushion to chair (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	initiated 8/27/25. A second focus area identified potential for nutritional problems due to Stage 4 Pressure Ulcer to L buttock (08/28/2025). Interventions for staff included supplements as ordered, notify the provider of any significant weight change and Pro Stat twice daily (BID) (8/28/25). A focus area identified EBP related to wound with wound vac (8/29/25) with the following interventions: gown and gloves to be worn for high contact activities, have PPE available for staff near the entrance to the resident's room and maintain signage on/outside resident's door (8/29/25). Resident #35's 9/25 Treatment Administration Record (TAR) revealed A. Vashe Wound Solution Therapy 475 ml use with a compress prior to dressing change on Monday, Wednesday and Friday - start date 9/27/25. B. Change wound vac on Monday, Wednesday and Friday. Vac to be set at 125 mm Hg every evening shift every Monday, Wednesday and Friday - start date 9/15/25. Observed on 9/29/25 at 10:24 AM signage for EBP outside Resident #35's room. Continuous observation began on 9/29/25 at 4:18 PM of Staff G performing wound care to Resident #35's Stage 4 Pressure Ulcer A. Staff G donned a gown in the hallway and sanitized bandage scissors at the treatment cart. B. Staff I, CNA, brought the resident into the room from a shower not wearing any PPE. The CNA donned gloves once in the room and assisted the resident with donning of non-slip socks for transfer from the shower chair to bed. C. Staff I did not don a gown or complete hand hygiene. D. Staff G stated she needed the Vashe Wound Solution from another cart and walked down the hall with the gown on to obtain supplies. E. Staff G entered the resident's room , placed the items on table donned gloves without hand hygiene and without changing gown. F. The staff transferred the resident to the bed using a Sit to Stand lift. G. Staff I remained in the room assisting with positioning the resident while wound care was completed. H. Staff G completed peri care with glove changes and hand hygiene. I. Staff G removed the dressing and packing, removed gloves, and washed hands. J. stated she did not have 4x4's and needed to go get them. The staff left the room wearing the gown to obtain the supplies and returned with 4x4's. K. Staff G donned gloves without hand hygiene or changing gown. L. Staff G applied the Vashe to the 4x4's and packed into the wound for 5 minutes, gloves changed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	without hand hygiene. M. Staff G completed peri care with glove changes and hand hygiene. N. Staff G applied Skin Prep, removed gloves, opened wound vac packaging, and donned new gloves. No hand hygiene. O. Staff I removed gloves, left the room, obtained a new bed pad, and donned new gloves with no hand hygiene. P. Staff G removed the gauze at 5 minutes with scant blood noted on the gauze, cut the foam packing to fit the wound, the wound vac dressing, touched her glasses, removed the wound vac tubing, completed the dressing, assisted Staff I with dressing the resident and then removed her gloves. No glove changes occurred during this sequence. On 10/1/25 at 5:45 AM Resident # 35 stated the staff did not wear gowns when assisting him with his personal care. On 10/2/25 at 12:34 PM the Infection Preventionist (IP) and MDS Coordinator, stated EBP would be used for anyone with chronic wound, catheter, any port - with direct care, wound care, changing linens, catheter cares. The IP stated EBP included the use of a gown, gloves and if there was fluid involved goggles and masks. The IP expected during wound care that glove changes would include hand hygiene. The IP stated staff should wash their hands before doing anything, apply clean gloves, provide a clean setup, change gloves with hand hygiene, and end with hand hygiene. The IP stated the expected staff to change their gown and not wear it outside the resident's room. On 10/2/25 at 1:17 PM the DON stated she expected staff to use a clean gown and gloves when entering a resident's room and to remove them when exiting a room. The staff stated a new gown and gloves were to be applied if returning to the room. The DON expected hand hygiene to be completed with glove changes. 5. Resident #89's MDS dated [DATE] revealed a BIMS score of 15/15 indicating normal cognition. The document revealed diagnoses of obstructive uropathy, Non-Alzheimer's Dementia, anxiety, hypokalemia and benign prostatic hyperplasia with lower urinary tract symptoms. The MDS indicated the resident had an indwelling catheter. Resident #89's Care Plan dated 9/24/25 revealed a focus area of requiring a urinary catheter related to diagnosis of obstructive uropathy (revision 5/28/25) with staff interventions of keeping a closed system as much as possible, measure and record output and catheter care BID and PRN (5/6/25). An EBP related to indwelling catheter for obstructive uropathy focus area (revised 9/24/25) contained interventions of gown and gloves to be worn for high contact activities (7/31/25), PPE available for staff near the entrance to the resident's room (7/31/25), signage on/outside of door (7/31/25), resident prefers to wear overnight foley bag and staff encourages resident to wear leg bag during the day and ask for assistance for draining (8/14/25). Observed on 9/29/25 at 10:31 AM Resident #89's catheter bag, no dignity bag, lying on the floor while the resident was sitting on his recliner. The resident had EBP signage outside of his door. Observed on 9/29/25 at 3:52 PM Resident #89 lying in bed with the catheter bag without a dignity bag (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	lying on the floor. Continuous observation on 10/1/29 began at 6:11 AM of Staff J, CNA, completing catheter care on Resident #89. A. Resident #89 was lying on the bed with his catheter bag hanging in a dignity bag on the side of the bed. B. Staff J applied hand sanitizer prior to entering the room. C. Staff J went into the bathroom, sanitized hands, donned a mask, gown, gloves, and obtained a graduate cylinder. D. The staff placed the graduate cylinder on the floor without a barrier and obtained alcohol prep pads. E. The staff noted that they did not have all necessary items, removed PPE, and left the room. F. Upon return to the room, Staff J completed hand hygiene, and donned all PPE. G. Staff J completed wiping of the catheter tubing with an alcohol prep pad, emptied the catheter bag with splashing onto the floor, wiped the tubing with a new alcohol prep pad and closed the catheter. H. The staff completed peri care with correct techniques. I. The staff emptied the graduate cylinder, removed PPE and completed hand hygiene. Observed on 10/2/25 at 9:30 AM Resident #89 seated on the recliner with the catheter bag hanging off the trash can. On 9/29/25 at 10:31 AM Resident #89 stated staff do not wear gowns in his room while emptying his catheter or assisting him with care. On 10/2/25 at 12:34 PM the IP and MDS Coordinator, stated they expected the following during catheter care: a barrier to be used with the graduate cylinder, trash bag, graduate cylinder, alcohol prep pad to be used when the tubing was disconnected, empty the catheter, alcohol prep pad to wipe the tubing, reconnect the tubing, and carry the trash bag with the graduate cylinder to the bathroom to get a measurement and empty. The IP expected the catheter bag to not be on the floor or hanging off of a trash can. On 10/2/25 at 1:13 PM the DON stated she expected catheter bags to be kept in a privacy bag and not on the floor. 6. On 9/30/25 at 8:35 AM Staff K, Maintenance, provided the diagrams of water flow, the Legionella Policy, Water Temp Logs and Water Flush Logs. Review of the Water Temperature Logs with Staff K noted the logs were completed weekly; however the entire month of September did not have any logs present. Review of the Water Flush Log found the months of April and September were not present. Staff K stated he would follow up with the Maintenance Supervisor and the Administrator regarding the missing logs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/30/25 at 9:25 AM the Administrator acknowledged she was aware of missing flushing logs for April and September and they were trying to locate them. On 10/1/25 at 6:08 AM the Administrator stated the missing logs were not located. The Administrator stated the Maintenance Director stated they had been completed but no one was able to locate them. On 10/2/25 at 7:02 AM the Administrator expected the Water Flushing Logs and Water Temperature Logs to be completed. The facility's Hand Hygiene - Center for Disease Control (CDC) Guidelines, updated 1/27/22, revealed staff should use an alcohol-based hand rub or wash with soap and water prior to touching a resident, before moving from dirty to clean task, after contact with blood/body fluids/contaminated surfaces and immediately after glove removal. The facility's Catheter Care Policy, revised 8/20/24, revealed staff should place a towel on the bedside table as barrier and set supplies on the work area, place a towel under the catheter tubing, tubing and bag should not touch the floor and the catheter bag must be covered with a dignity cover when visible. The facility's Transmission-Based Precautions (Isolation Precautions), updated 6/5/24, contained a reference to EBP indicating it was an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The document identified residents who had an infection or colonization with a CDC-targeted multidrug-resistant organism (MDRO), chronic wounds and indwelling medical device. PPE identified in the document included gloves and gown which were to be removed and hand hygiene performed prior to leaving the resident-care area. The document identified the following high-contact areas: dressing, bathing/showering, device care and wound care. The U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign outside of residents' rooms revealed providers and staff must wear gloves and gown during high contact resident care activities including dressing, bathing, transferring, hygiene, changing briefs or assisting with toileting, and wound care. The facility's Legionella Prevention Water Management Plan, dated 8/1/17, identified a risk management approach to identify control limits of water flow rate, temperature and disinfectant residual. The document indicated a member of the Water Management Team will monitor the control locations and limits routinely. A facility document, Hazards/Control Measures/Corrective Action Legend, in the Water Flushing Log Book revealed water temperature should be checked weekly at varying locations in hot water distribution 60 seconds after flushing. The document further revealed that for stagnation the facility should have a weekly flush at terminal ends unused for 7 days.

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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 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** Based on observations, resident and staff interviews, document reviews and policy review the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 6 of 27 residents reviewed (Resident #35, #42, #10, #30, #50 and #76). The facility reported a census of 90.Findings include: 1. Resident #35's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The document listed Resident #35 as frequently incontinent of bladder and bowel. The MDS listed the resident as requiring substantial/maximal assistance for toileting hygiene, bed mobility and transfers. Resident #35's Care Plan dated 9/24/25 revealed an Activities of Daily Living (ADLs) focus area, revised 9/9/25, with interventions of assisting with cares (9/3/25), bilateral bed rails (9/3/25), and reporting further deterioration to provider (9/3/25). The document included a urinary incontinence focus area dated 9/9/25 with interventions including incontinence care following each incontinence episode (9/9/25), report signs and symptoms of urinary tract infections (UTIs), and assist to toilet (9/9/25). On 9/30/25 at 2:46 PM Resident #35 stated call lights take a long time to be answered, sometimes longer than 15 minutes. The resident stated staff will come in at times, shut the call light off, say they will return and then do not. The resident stated he has been late to activities due to staff not answering his call light. On 10/1/25 at 5:45 AM Resident #35 stated he has been late to activities due to staff not answering his call light. 2. Resident #42's MDS dated [DATE] revealed a BIMS score of 15/15 indicating normal cognition. The document listed Resident #42 as frequently incontinent of bladder and bowel. The MDS provided the resident required substantial/maximal assistance with toileting hygiene, and transfers. Resident #42's Care Plan dated 9/25/25 revealed an ADL focus area (7/24/25) that included interventions with providing assistance with care, allowing extra time to complete ADLs and reporting further deterioration to the provided (7/24/25). The document contained a focus area of at risk for skin breakdown related to incontinence and impaired mobility (revised 9/25/25) with interventions of keeping areas clean and dry as possible, minimize skin exposure to moisture (7/24/25) and skin treatments as ordered (9/25/25). On 9/29/25 at 10:38 AM Resident #42 stated it would take 45 minutes or longer to answer call lights. The resident stated the staff would answer the call light and then leave with statements of takes 2 to get you up, can't get you up as we are assisting other residents either to or from the dining room, or we have reports to do. The resident stated assistance at night was limited. Resident #42 revealed she has had incontinence episodes due to staff not answering her call light and that it makes her mad and uncomfortable. 3. Resident #50's MDS dated 926/25, revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The MDS identified a diagnosis of a stroke and dependent on staff (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for toileting and transfers. Interview on 9/29/2025 at 11:21 AM, Resident #50 stated he was at the facility receiving therapy after a stroke, was doing therapy daily, and it usually takes 30 minutes for the staff to answer his call light. 4. Resident #76's Minimum Data Set (MDS) dated [DATE] revealed a BIMS score of 15/15 indicating normal cognition. The document listed the resident as occasionally incontinent of bladder and required substantial/maximal assistance for toileting hygiene, bed mobility and transfers. Interview on 9/29/2025 at 3:41 PM, Resident #76 stated staff come in and talk to each other or look at their phone and can wait 1 1/2 - 2 hours for them to answer the call light, days and evenings are the worst, nights is better. Resident stated she times it with the clock on her wall. 5. Observation on 9/30/2025 at 4:27 PM, Staff U, Certified Medication Aide sitting at the Nurses' Station on a cell phone. Staff O, LPN instructed Staff U to go see if the other staff needed assistance. Review of document titled, Alarm Response Report provided by the Administrator revealed: a. room [ROOM NUMBER] had call lights with a response time of longer than 15 minutes from 9/24/25 - 10/1/25 on: 9/25/25 at 6:35 PM 24 minutes and 09 seconds. 9/27/25 at 6:50 PM 17 minutes and 25 seconds. 9/28/25 at 7:19 PM 18 minutes and 02 seconds. 9/29/25 at 8:46 AM 25 minutes and 04 seconds. 9/29/25 at 5:01 PM 19 minutes and 32 seconds. b. room [ROOM NUMBER] had call lights with a response time longer than 15 minutes from 9/24/25 - 10/1/25 on: 9/24/25 at 6:43 PM 27 minutes and 11 seconds. 9/25/25 at 4:51 PM 16 minutes and 55 seconds. 9/26/25 at 12:54 AM 23 minutes and 36 seconds. 9/26/25 at 4:30 PM 1 hour and 58 seconds. 9/26/25 at 7:20 PM 15 minutes and 39 seconds. 9/26/25 at 7:36 PM 30 minutes and 2 seconds. 9/28/25 at 7:07 AM 39 minutes and 27 seconds. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/28/25 at 7:24 PM 21 minutes and 38 seconds. 9/29/25 at 7:10 PM 22 minutes and 47 seconds. c. room [ROOM NUMBER] had call lights with a response time of longer than 15 minutes from 9/24/25 - 10/1/25 on: 9/24/25 at 4:31 AM 44 minutes and 15 seconds. 9/24/25 at 6:53 AM 17 minutes and 49 seconds. 9/27/25 at 5:42 AM 17 minutes and 7 seconds. 9/27/25 at 6:38 PM 18 minutes and 51 seconds. 9/28/25 at 6:24 AM 18 minutes and 23 seconds. 9/28/25 at 6:28 PM 21 minutes and 15 seconds. 9/29/25 at 5:41 AM 17 minutes and 30 seconds. 9/30/25 at 4:20 AM 18 minutes and 44 seconds. 9/30/25 at 8:29 AM 18 minutes and 42 seconds. d. room [ROOM NUMBER] had call lights with a response time of longer than 15 minutes from 9/24/25 - 10/1/25 on: 9/30/25 at 1:38 PM 22 minutes and 22 seconds. 10/1/25 at 4:50 AM 24 minutes and 34 seconds. On 10/2/25 at 1:45 PM the DON stated the facility's expectation was that call lights would be responded to in less than 15 minutes. On 10/2/25 at 2:00 PM the Administrator stated she expected the call lights would be responded to in less than 15 minutes. The Administrator acknowledged on the Alarm Response Report there were several call light times that were reported longer than 15 minutes. Review of policy dated 10/31/24 titled, Call Light Response documented the objective was to ensure timely and efficient response to resident call lights, enhancing resident safety and satisfaction. Staff members were required to respond to resident call lights within 15 minutes of activation. Call light response data would be recorded and stored for a period of 7 days. This data would be reviewed regularly to identify patterns, improve response times and address any issues related to call light usage.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on observations, resident and staff interviews, record review, and policy review the facility failed to complete a significant change comprehensive assessment when a resident had a decline in condition for 1 (Resident #76) of 3 residents reviewed. The facility reported a census of 90 residents. Findings include:The Minimum Data Set (MDS) for Resident #76, dated 7/31/25, included diagnoses of heart and osteoarthritis. The MDS identified the resident was independent with eating, supervision or touching assistance with upper body dressing, substantial/maximal assistance with transfers, toileting and lower body dressing, and was occasionally incontinent of bladder. The MDS indicated the resident had a Brief Interview for Mental Status score of 15, indicating no cognitive impairment for decision-making. Resident's Care Plan, target date 11/7/25, identified the following: a. Focus: Is at risk for decline in activities of daily living (ADLs) with interventions of assist with dressing in the morning, at hour of sleep (HS), and as needed (PRN), assist with positioning PRN with left upper grab to bed to assist with repositioning, assist with toileting before and after meals, HS, and PRN, feeds self after staff set up and assist PRN, with latest revision date of 12/31/24 b. Focus: Is at risk for injury from fall related to impaired mobility with intervention of transfers via full body lift with 2 assist, revised 9/12/25. c. Focus: Resident experiences bladder incontinence related to diuretic (medication to decrease fluid in the body) use and impaired mobility, with interventions to assist to toilet before and after meals, HS and PRN, provide incontinence care after each incontinence episode with date initiated 8/6/25. Interview on 9/30/2025 at 9:41 AM Resident stated she has had a decline in her ADLs, she was moved to the assist to dine table in the dining room as staff have to feed her now due to she can't lift her arms high enough most of the time, she now requires a full body lift to transfer, is incontinent of bladder all of the time since using the full body lift as when they lift her up she goes every time as she is not able to control it anymore, and uses a bedside commode for bowel movements. The resident stated it has been a month or longer since her decline. Observation on 10/01/2025 at 7:40 AM, Staff P, Certified Nurse Aide (CNA) and Staff B, CNA transferred the resident from the recliner to the bed with a full body lift and completed incontinent cares with staff doing the turning for cares without any assist from the resident. Interview on 10/01/2025 at 7:48 AM, Staff P stated the resident has had a big decline since about 1 month ago. Staff P stated the resident has switched to a full body lift from a standup lift as the resident just went numb and wasn't able to stand and be safe, wears dentures and staff clean and give the dentures to her to put in and sometimes she can and sometimes not, moved to assist to dine table for meals and encourage her to feed self, but frequently needs staff to do, and was continent of bladder and bowel and would place on the toilet with the standup lift but is no longer continent of bladder. Staff P stated she is not aware of resident receiving any therapy. Observation on 10/01/2025 at 12:17 PM, Staff P assisting the resident to dine. Staff encouraged the resident to feed self by placing a curved spoon in the resident's hand and scooping food onto the spoon for the resident and the resident was not able to consistently get the spoon to her mouth and the food would fall off the spoon. Interview on 10/01/2025 at 12:41 PM, Staff C, MDS Coordinator stated she reads report every day to see resident changes and any differences with them. Staff C stated the staff have not reported a decline with the resident to her. Staff C stated with the resident changing from independent in the dining room to the assist table, continent to incontinent, and transfer changed from stand lift to full lift a significant change MDS should have been done that she should have noticed after 7 days and started a significant change with the expectation to start significant change 7 days after decline. Facility Comprehensive Assessment and Reassessment, effective 5/10/17, revealed the Resident Assessment Coordinator will ensure the MDS assessment is completed with 14 days of a significant change in status and a significant change in the resident's condition shall require a reassessment with changes in the plan of care reflecting the change of condition.

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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** Based on clinical record review, staff interview, and policy review the facility failed to complete a Pre-admission Screening and Resident Review (PASRR) for 1 of 1 residents (Resident #6), who was diagnosed with new mental disorder diagnoses since admission to the facility. The facility reported a census of 90 residents. Findings include: Review of Resident #6's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7/15 indicating severe cognitive impairment. The document indicated the resident had hallucinations, delusions, verbal behavioral symptoms directed toward others, 1 -3 days during the reporting period, other behavioral symptoms not directed toward others daily, and the resident's behavior was worse than prior assessment. The MDS further revealed diagnoses of Non-Alzheimer's Dementia and psychotic disorder. The document provided the resident took antipsychotic medication. Resident #6's Care Plan dated 6/11/25 contained a impaired decision making focus area initiated 10/14/24 with interventions of explaining procedures and cares prior to initiating, provision of short/simple instructions, and task segmentation as needed initiated 10/14/24. An additional focus area of short term memory impairment and poor decision making abilities due to dementia initiated 3/12/25 provided interventions of assisting with decision making throughout the day and provision of verbal and visual reminders dated 3/12/25. The Care Plan anti-psychotic medication for diagnosis of delusional disorder and yelling out at times dated 3/12/25 referred to interventions of administration of antipsychotic medications, discussion of medications at Care Plan Conference, identification of target behaviors and non pharmacological interventions. The Care Plan failed to identify any PASRR focus area or interventions.The electronic medical record (EMR) Census indicated the Resident #6 admitted on [DATE].The EMR Medical Diagnoses for Resident #6 included:Unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (10/9/24),Delusional disorders (6/6/24)The Clinical Physician Orders printed 10/1/25 listed the following orders:Quetiapine 25 mg 1 tablet daily for delusional disorders, metabolic encephalopathy and unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Quetiapine 25 mg 1.5 tablets at bedtime for delusional disorders, metabolic encephalopathy and unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Target behavior: delusions (talking to people not present), verbally abusive towards staff, yelling/calling out.Review of a facility provided document titled, PASRR Notice of Nursing Facility Approval, dated 3/27/23 revealed a summary of findings indicating that Resident #6 that did not show evidence of a serious mental illness. an intellectual or developmental disability(IDD) or diagnosis of dementia/neurocognitive disorder that appeared to require PASRR intervention. The document included that if changes occurred or new information refuted the findings, a new screen must be completed. The EMR Patient Note for Mental Health dated 1/16/25 included a medical diagnosis of Metabolic Encephalopathy. The document included a psychiatric medication of Seroquel 25 mg.On 10/2/25 at 7:54 AM Staff H, Social Services, acknowledged there was only a Level I PASRR present in Resident #6's EMR and confirmed there was no other documentation related to a PASRR in the resident's soft chart. On 10/2/25 at 8:00 AM the Administrator concurred there was no documentation in the Path Tracker indicating a new PASRR had been submitted. The Administrator stated she thought the facility had fixed all of those, but must have missed this one. The Administrator expected if a resident had a new diagnosis or medication they needed to have new PASRR. On 10/2/25 at 9:01 AM the Administrator indicated the facility did not have a PASRR policy, but followed the regulations.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review the facility failed to provide a comprehensive care plan related to high risk medications for residents with an order for diuretics for 1 of 5 residents (Resident #6) reviewed. The facility reported a census of 90 residents. Findings include: Review of Resident #6's Minimum Data Set (MDS) dated [DATE] revealed diagnoses of heart failure, hypertension, Non-Alzheimer's dementia, and psychotic disorder. The MDS further revealed that during the look back period Resident #12 received diuretic medication daily. Review of the Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders revealed an order for Furosemide 20mg 1 tablet twice daily with a start date of 8/26/25. Review of Resident #6's Care Plan with a revision date of 3/12/25 revealed no documentation of diuretic medications usage.Interview 10/01/2025 at 2:40 PM with Staff C Licensed Practical Nurse (LPN) revealed that diuretics should be in the care plan. Staff C then confirmed that diuretics were not in Resident #6's care plan, and revealed that it should be. Interview 10/01/2025 at 2:42 PM with the Director of Nursing (DON) revealed that her expectation would be for diuretics to be on resident care plans if they were taking the medication. Review of a facility provided policy titled, Detailed Assessment and Reassessment dated [DATE] revealed:a. Detailed care planning will be documented on the resident's plan of care.

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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. Based on observations, clinical record review, staff interviews, and policy review the facility failed to provide needed services in accordance with professional standards by leaving medications in a residents room for 2 of 8 residents (Resident #75 and #78). The facility reported a census of 90 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #75, dated 7/31/25 did not document a Brief Interview for Mental Status (BIMS). Review of EHR titled, Progress Notes dated 8/11/25 revealed a BIMS evaluation with a BIMS of 15. The MDS also documented a diagnosis of chronic obstructive pulmonary disease with acute exacerbation. Observation on 9/29/25 at 10:54 AM revealed a nebulizer machine with clear liquid present and a vial of albuterol sulfate 0.5mg/3mg per 3 mL lying full on Resident #75's bedside table. On 9/29/25 at 10:56 AM Resident #75 stated the nurses occasionally leave the nebulizer medication on the bedside table for the next dose. Resident #75 stated the nurses never clean the nebulizer or mask. Review of Resident #75's Medication Administration Record (MAR) documented a physician's order for ipratropium / albuterol to be inhaled 1 vial per nebulizer 4 times daily and a physician's order for levalbuterol 0.31mg to be inhaled 1 vial per nebulizer 3 times a day as needed (PRN). Review of Resident #75's Electronic Health Record (EHR) titled, Orders documented physician's orders for ipratropium / albuterol to be inhaled 1 vial per nebulizer 4 times daily and a physician's order for levalbuterol 0.31mg to be inhaled 1 vial per nebulizer 3 times a day as needed (PRN). On 9/29/25 at 11:13 AM Staff F, Licensed Practical Nurse (LPN) stated Resident #75 had 2 different breathing treatments. Staff F explained one breathing treatment was 4 times a day and the other was PRN 3 times a day. Staff F acknowledged she was the nurse that administered the breathing treatment this morning. Staff F acknowledged she did not clean the nebulizer. Staff F stated she liked to at least rinse the nebulizer out after every treatment. Staff F explained she administered the PRN treatment to Resident #75 that morning. Staff F stated Resident #75 refused the albuterol breathing treatment. Staff F acknowledged she left the albuterol on Resident #75's bedside table. Staff F stated she did not think that Resident #75 had any self administration orders. On 10/1/25 at 3:15 PM the DON stated during the incident with Resident #75's medication being left in the room she would like to have seen the mask cleaned after use. The DON stated the facility's expectation was the albuterol would have been returned to the medication cart as long as it had not been opened if the medication was refused and documented in the MAR. 2. The MDS for Resident #78, dated 8/14/25, included diagnoses of Non-Alzheimer's Dementia and depression. The MDS indicated the resident had a BIMS score of 12, indicating mild cognitive impairment for decision-making. Resident #78's Care Plan, revised 11/22/24, revealed10/01/2025 10:07 AM Care Plan, target date 11/14/25, identified a focus of: I have short term memory impairment and poor decision-making abilities at times with the goal to make daily decisions regarding my care with limited assistance or cueing from staff. The Care Plan lacked any documentation of self-administration of medications. Observation on 9/29/2025 at 1:47 PM, Resident #78 was lying in bed and a cup with 3 pills was sitting (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the bedside table. The resident stated the pills were Tums and he needed them available for when he wants them. The resident stated the staff leave the pills for him. Interview on 9/29/25 at 2:15 PM, Staff O, LPN confirmed the 3 pills were Tums and stated she had observed the pills there the day before when she had worked 6 AM – 6 PM. Staff O stated she did not give them to the resident but thinks he has an order to have the pills. Staff O was unable to provide an order for the medications at bedside. Interview on 10/01/2025 at 9:53 AM, Staff I, Certified Medication Aide stated medications are to be given to the resident, observe until the resident swallows the medications, and would not leave any medications at a resident's bedside. Staff I confirmed the resident does not have an order to leave medications at the bedside. Staff I further stated she has observed Tums in a cup on the resident's table before, approximately 2 months ago but was not aware who left them for the resident. Facility Medication Administration policy, revised 6/30/23, revealed medications shall be stored in a locked medication cart and/or medication room with the procedure when administering to identify the resident, administer medication, assure resident has taken the medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, family interview, staff interviews, and policy review the facility failed to ensure the residents were free of significant medication errors to 1 of 4 residents reviewed (Resident #38). The facility reported a census of 90 residents. Findings include: Review of Resident #38's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment. The MDS further revealed diagnoses of hypertension, renal insufficiency, and Alzheimer's disease. Interview 9/29/25 at 3:25 PM with Resident #38's family member revealed that Resident #38 received another resident's medication in addition to Resident #6's own medications. The family member revealed that Resident #38 received another resident's blood pressure medication, magnesium, Tylenol, and a fourth medication. The family member stated that Resident #38 received more than twice their normal amount of blood pressure medication. The family member spoke with the Director of Social Services about what happened, and was told it was a new Certified Medication Aide (CMA) who had two cups of medications. The CMA put another resident's medications down, and provided Resident #38 with her medications. The family member further revealed that she was told the CMA turned their attention to something else, and when they turned back the resident had taken the other resident medications. Review of a facility provided document titled, Medication Error Report dated 9/4/25 revealed that a nurse had given another resident's medication to another resident. The document further revealed that the resident who received the wrong medication was administered fluids to maintain blood pressures. Review of a facility provided undated statement from Staff D Licensed Practical Nurse (LPN) revealed Staff D prepared Resident #38's medications. Staff E LPN asked who the medications were for, and Staff D replied that they were for Resident #38. Staff E then responded that he could give the medications to Resident #38. Staff D allowed this, and then prepared Resident #35's medications. Staff D then revealed that she became confused, and didn't realize/forgot that Resident #38's medications were already given by Staff E. Staff D further revealed that she then gave Resident #35's medications to Resident #38 thinking they were Resident #38's medications. Staff D revealed she did not realize what she did until later. Review of another facility provided undated statement from Staff E revealed that he administered Resident #38's medications, and Staff D who was training then proceeded to give Resident #38 another resident's medication.Review of Resident #38's EHR page titled, Progress Notes revealed an entry dated 9/4/25 at 9:50 AM that the floor nurse notified another nurse about administering the wrong medications to Resident #38. The nurse that was notified then notified the provider and the provider requested to have blood pressures completed every 30 minutes for the first 4 hours then hourly for the next 24 hours. Further review of the EHR Progress Notes revealed and entry 9/4/25 at 9:55 AM a new order was obtained from the Primary Care Provider (PCP) to hold Resident #38's blood pressure medications on the morning of 9/5/25, if Resident #38's systolic blood pressure was below 140. Another entry 9/4/25 in Resident #38's Progress Notes at 8:00 PM revealed a health status note documenting that Resident #38 was slightly hypotensive and bradycardic in relation to her previously recorded vital signs.Progress Notes dated 9/5/25 at 7:43 AM revealed that Resident #38's Lisinopril 40 mg tab and Amlodipine 2.5mg tab were held at that time related to Resident #38's blood pressure being 102/70. Progress Notes review of an entry dated 9/5/25 at 9:02 AM revealed Staff E obtained an order from the Nurse Practitioner (NP) for STAT subcutaneous saline fluids. Staff E further documented that the order was Saline fluids subcutaneous 1 Liter bag at 100 milliliters every hour for the rate. Progress Notes review of an entry dated 9/5/25 at 12:25 PM revealed Resident #38 had been exhibiting low blood pressures through the night and the morning and at 12:28 PM the subcutaneous infusion of 1000 milliliters was administered. Interview 10/2/25 at 10:10 AM with the Director of Nursing (DON) and the Administrator revealed that Staff D was passing the medications and Staff E offered to help. Staff E passed Resident #38's medications after Staff D (continued on next page)

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	165524	A. Building B. Wing	10/02/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prepared them. Staff D was then preparing another Resident's medications and gave them to Resident #38. Interview 10/02/2025 at 10:50 AM Staff E was in the dining room and was training Staff D. Staff E then revealed that Staff D got medications ready, and Staff E then passed the pills to Resident #38. Staff D then passed the medications of to Resident #38. Staff E then revealed that he and Staff D were unsure that they didn't pass Resident #28's medications until Resident #28 said something to them about 20 minutes later. Staff E then revealed that he did notify the physician. Staff E further revealed that Resident #38's blood pressure normally runs low, but when it got below the normal he called back to the physician and got an order for intravenous (IV) fluids. Staff E revealed that this was Staff D's first day out of nursing school, and she was performing the medication checks. Interview 10/02/2025 at 11:33 AM with the DON revealed that she would have liked to have seen the staff take their time when passing medications, and to only pass the medications that they have prepared. Review of a facility provided policy titled, Medication Administration with a revision date of 6/30/23 revealed:a. Medications shall be administered per physician order.b. Remove medication with labels facing the nurse. Check labels to Medication Administration Record (MAR). Verify resident, drug, strength, dose, route and hours of administration with MAR.