STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165584	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home	1005 Lincoln Avenue Dubuque, IA 52001

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 - Actual harm 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, document review, procedure review, manufacturer use manual, and staff interview, the facility failed to ensure Certified Nursing Assistants (CNAs) locked wheelchair brakes during pivot and full body mechanical lift transfers for 1 of 4 residents reviewed (Resident #23). This failure resulted in Resident #23 falling and sustaining a left ulna fracture (a break in the ulna is one of the two long bones in the forearm (running along the pinky-finger side). The facility identified a census of 63 residents.Findings include:1.The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #23 exhibited a long/short memory problem, and had severely impaired daily decision-making ability. Resident #23 did not exhibit behaviors. Resident #23 did not exhibit upper/lower functional limitations in range of motion. She utilized a wheelchair and was dependent upon staff for chair/bed to chair transfers. The MDS listed diagnoses of Alzheimer's Disease, arthritis, osteoporosis, anxiety, and depression. The MDS listed one fall without injury since the last assessment. A Nursing Assistant Orientation Form dated [DATE] documented Staff A, CNA received Chair to Toilet Transfer orientation training which was signed off by Staff B, Certified Medication Aide (CMA). The Activities of Daily Living (ADL) Self-Care Performance Care Plan for Resident #23 directed as of [DATE] to provide a one assist for transfers and toileting. An Incident Report dated [DATE] written by Staff C, Licensed Practical Nurse (LPN) documented at 5:10 PM Resident #23 sustained a fall in her room which resulted in a skin tear on the left forearm and a bump on the back of her head. The CNA was transferring the resident from the toilet to the wheelchair. The wheelchair rolled out from under the resident as the wheelchair brakes were not locked. The Resident fell back onto the bathroom floor. Resident #23 stated her arm and head hurt. The Incident Report further documented Resident #23 was cleaned up, placed in the wheelchair, and taken out to the dining room table for dinner. The Resident's Vitals Signs were temperature 98.6, pulse 75 beats per minute (BMP), respirations 18, blood pressure 166/86, and oxygen saturation 95% on room air. A [DATE] Fall Prevention Intervention Document written by Staff C documented equipment placement, mobility, and brakes off on the wheelchair as possible contributing factors as to why the fall occurred. The root cause of the fall was the brakes were not locked on the wheelchair, and more assistance was needed. A Employee Notice of Discipline form dated [DATE] for Staff A documented on [DATE] Staff A completed an unsafe transfer by not locking the wheelchair brakes which resulted in a resident falling and sustaining an ulna fracture. Staff A documented that she forgot to lock the wheelchair. The Form specified the Action to be Taken was one to one training with a therapist. A Wound Weekly Observation Form dated [DATE] documented Resident #23 with a left forearm skin tear that measured 5 Centimeters (CM) length by 5.5 CM width x 0 CM depth, acquired on [DATE].Review of the [DATE] X-ray report documented Resident #23 had a left forearm x-ray, two views due to swelling, pain and warm to touch post fall. The X-ray Impression documented an outside distal ulnar fracture.Review of a Physician Order and Progress Note dated [DATE] documented a left distal ulna (wrist) fracture. The Provider ordered a short arm cast for two weeks, non-weight bearing to the left upper extremity, ice as needed and follow up with the provider in two weeks.An Undated, (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 - Actual harm Residents Affected - Few	Unsigned Statement for Staff A documented it was about 4:50 PM. She had gone to Resident #23's room to get her up for dinner. Staff A sat Resident #23 on the side of the bed placed the gait belt and transferred the resident into the wheelchair and wheeled her into the bathroom. Staff A transferred Resident #23 to the toilet. Resident #23 sat for a few minutes, then became antsy and wanted to leave. Staff A pulled the wheelchair to her right side which was the resident's left side. Resident #23 was wanting to get up and go and was moving toward the wheelchair which wasn't locked. The wheelchair turned and spun away and Resident #23 fell, bumping her left arm off of the wheelchair and bumping her head. An Undated, Unsigned Statement for Staff C documented she was on duty the evening of [DATE]. She saw Resident #23's call light on and started walking toward her room. Resident #23's family member informed her the resident had fallen in the bathroom. Staff A was with the resident in the bathroom. Staff C assessed the resident's range of motion which was within normal limits.An Undated, Unsigned Document identified the facility Corrective Actions for Staff A to do an hour of 1 to 1 training with the Occupational Therapist (OT) on [DATE] from 1:30 - 2:30 PM. After, OT provided Staff A with written notes to review and asked Staff A to write down things she learned. The Director of Nursing (DON) and Administrator met with Staff A to discuss how the training went and what she learned. The Restorative Nurse then watched Staff A completed resident transfers on [DATE] and Staff A did well. The Document further specified Staff A would meet with OT again on [DATE] for role play and various scenarios with residents that Staff A may encounter for safety. On [DATE] at 1:53 PM, Staff D, CNA reported wheelchair brakes were to be locked before a transfer was started, before the resident got up or sat down in the wheelchair. On [DATE] at 2:41 PM, Staff E, Licensed Practical Nurse (LPN) reported wheelchair brakes should be locked before the resident stood up or sat down in the wheelchair during a transfer. On [DATE] at 8:08 AM, Staff C stated she was the nurse on duty the night of Resident #23's fall. The resident's call light came on around suppertime and she was walking that way to see if the resident needed help. Resident #23's family member was standing outside the room and informed her the Resident had fallen. Staff C assessed Resident #23's vital signs, range of motion, pain, and skin tear to the left forearm. The resident was trying to get up off the toilet and it happened so fast and Staff A forgot to lock the wheelchair brakes. The resident lost her balance and went to the ground. Staff C explained the CNA's are to have the gait belt on, wheelchair brakes locked, and have the chair or bed right next to the resident transferring to the resident's strong side with the right amount of assistance. During an interview on [DATE] at 9:50 AM, Staff F, Director of Nursing (DON) verbalized she was contacted by phone and updated on Resident #23's fall by Staff C. When queried on the root cause of the fall, Staff F voiced Staff A did not lock the wheelchair brakes during the transfer. Staff A should have locked the wheelchair brakes for the transfer.In an interview on [DATE] at 9:54 AM, the Administrator reported the wheelchair brakes were to be locked during transfers to the wheelchair. Interview on [DATE] at 10:02 AM, Staff F and Staff G both voiced they expected the staff to lock the wheelchair brakes during 1-2 person pivot transfers. The Patient Transfers (Procedure), undated, under Environmental Setup specified before starting to confirm patient readiness, apply the gait belt, ensure proper footwear, and lock the wheelchair brakes. 2. Resident #23's MDS dated [DATE] documented Resident #23 was rarely/never understood, exhibited a long/short memory problem, and had severely impaired daily decision-making ability. The MDS documented Resident #23 utilized a wheelchair and was dependent on chair/bed to chair transfers. The MDS further documented Resident #23 had sustained one fall without injury and one fall with injury (not major injury) since the prior assessment.The ADL Self-Care Performance Deficit Care Plan intervention dated [DATE] directed Resident #23 did not walk, and the intervention dated [DATE] revealed the resident utilized a wheelchair for all locomotion. The Full Body Mechanical Lift (Brand Specific) User Manual, provided by the facility, Transferring to a Wheelchair included the following steps:-Ensure the legs of the lift are in the open position.-Move the wheelchair into position.-Engage the rear wheel locks of the wheelchair to prevent movement of the chair.The Full Body Mechanical Lift (Brand Specific) User Manual included a WARNING! The wheelchair wheel (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	locks MUST be in a locked position before lowering the patient into the wheelchair for transport. Observation on [DATE] at 10:55 AM revealed Staff H, CMA and Staff I, CNA placed a full body mechanical lift sling under Resident #23. Staff I raised Resident #23 in the full body mechanical lift and positioned the lift base around the wheelchair. Neither Staff H or I locked the wheelchair brakes before Resident #23 was lowered into the wheelchair. Observation on [DATE] at 1:10 PM revealed Staff H and I placed the wheelchair inside the base of the full body mechanical lift. Staff H and I attached the lift sling to the spreader bar. Neither CNA locked the brakes on the wheelchair. Staff H stood behind the wheelchair and Staff I lifted the resident up via the full body mechanical lift. Both staff steadied Resident #23 as the wheelchair moved slightly as Resident #23 was lifted up out of the wheelchair to the bed. On [DATE] at 1:14 PM, Staff H reported she had seen a few CNAs transfer residents with the wheelchairs unlocked but it had been a long time ago. She stated the facility had the therapist come in and provide transfer training including locking the brakes on the wheelchair. She hadn't seen any problems since that time. On [DATE] at 8:08 AM, Staff C queried if the wheelchair was supposed to be locked during full body mechanical lift transfers and responded, Yes.During an interview on [DATE] at 9:40 AM, Staff J, CMA explained when provided a full body mechanical lift, they ensured the resident was positioned correctly in the lift sling, and attached the sling to the lift. One aide pulled the lift out while the second aide guided the resident off the bed, and the resident was then lowered into the wheelchair. The brakes were to be locked on the wheelchair when the resident was lowered into the wheelchair so the wheelchair doesn't move back during the transfer. If the wheelchair moved during the transfer, the resident could fall or be injured.During an interview on [DATE] at 10:10 AM, Staff F reported the wheelchair brakes were supposed to be locked during the full body mechanical lift transfers. The Safe Resident Handling/Transfer Policy, revised [DATE], specified to ensure residents were handled and transferred safely to prevent or minimize risks of injury and provide and promote a safe, secure and comfortable experience for the resident in accordance with current standards and guidelines. The Policy Explanation stated all residents require safe handling when transferred to prevent or minimize the risk for injury to themselves. The Policy directed staff would perform mechanical lifts/transfers according to the manufacturer's instructions for the use of the device.