STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285270	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home, Inc	515 West First Street Minden, NE 68959

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Licensure Reference Number 175 NAC 12-006.05(D) Licensure Reference Number 175 NAC 12-006.05(E) Based on record review and interview the facility failed to ensure that the resident/resident representative was informed of the risks, benefits, and alternative treatments for the use of antipsychotic medication (any medication that affects behavior, mood, thoughts, or perception used to manage psychotic disorders) as required for 2 of 2 residents reviewed (Residents 59 and 42). The facility census was 62. Findings are: A. Record review of the facility policy titled Antipsychotic Medication Use dated March 2015 revealed that antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional, psychiatric, social, and environmental causes of behavioral symptoms have been identified and addressed. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. Record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) dated 4/2/25 for Resident 59 revealed that Resident 59 admitted into the facility on 3/26/25. The MDS revealed that Resident 59 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 7/15 indicating that the cognitive function of Resident 59 was severely impaired. The MDS revealed that Resident 59 received antipsychotic medications since admission. Record review of the Order Summary (a listing of all current physician orders for the resident) dated 6/26/25 for Resident 59 revealed an order for Seroquel 100 milligrams (an antipsychotic medication) by mouth at bedtime with an order date of 3/26/25. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 59's Medication Administration Record (MAR, a legal record of the medications administered to a patient at a facility by a health care professional) for March 2025 dated 6/26/25 revealed documentation that 100 milligrams of Seroquel were administered on 3/26/25, 3/27/25, 3/28/25, 3/29/25, 3/30/25, and 3/31/25. Record review of the MAR for April 2025 for Resident 59 dated 6/26/25 revealed documentation that Seroquel 100 milligrams was administered daily to Resident 59. Record review of the MAR for May 2025 for Resident 59 dated 6/26/25 revealed documentation that Seroquel 100 milligrams was administered daily to Resident 59. Record review of the MAR for June 2025 for Resident 59 dated 6/26/25 revealed documentation that Seroquel 100 milligrams was administered daily at 8:00 PM to Resident 59 from 6/1/25 through 6/25/25. Record review of the Care Plan dated 6/23/25 for Resident 59 revealed that Resident 59 used psychotropic medications for dementia with psychotic disturbance. Interventions included to administer psychotropic medications as ordered and monitor for side effects and effectiveness. Discuss with the physician and family regarding ongoing need for use of medication. Review behaviors, interventions, and alternate therapies. Monitor for adverse reactions including unsteadiness, frequent falls, and refusal to eat. Record review of the Progress Note for Resident 59 dated 6/6/25 at 8:58 AM revealed that staff have noted that Resident 59 is very sleepy and has been sleeping through meals. A fax was sent to the resident's physician to update on the resident's condition. Record review of the Progress Note for Resident 59 dated 6/6/25 at 11:04 AM revealed that the resident's physician returned the fax and documented that Resident 59 was probably overmedicated. Record review of the electronic health record (EHR) for Resident 59 revealed that it contained no documentation that the resident or family were informed of the risks, benefits, or alternative treatments for the use of the antipsychotic medication Seroquel. Record review of the paper chart medical record for Resident 59 revealed no documentation that the resident or family were informed of the risks, benefits, or alternative treatments for the use of the antipsychotic medication Seroquel. Interview on 6/26/25 at 11:28 AM with the facility Director of Nursing Services (DNS) confirmed that the facility did not have documentation of resident/family education on risks, benefits, or alternate therapy regarding the resident antipsychotic Seroquel use. B. Record review of an admission Record dated 06/23/2025 for Resident 42 revealed an admission date of 05/16/2023, and diagnosis information revealing: -Unspecified dementia, unspecified severity, with other behavioral disturbance (characterized as agitation including verbal and physical aggression). -Bipolar disorder (mental health condition characterized by extreme shifts in mood, energy, and activity levels, causing significant disruptions in daily life). (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Personal history of other mental and behavioral disorders. -Anxiety disorder Record review of a Care Plan Report with a revision date of 11/04/2024 for Resident 42 revealed: - Has potential to be verbally aggressive related to dementia, ineffective coping skills, mental /emotional illness, diagnosis (dx) of Bipolar and a history of alcohol abuse. -Impaired cognitive function related to dx of dementia, history of alcohol use in remission, dx of bipolar as evidenced by impaired decision making. -Use of psychotropic medication related to dx and history of Bipolar. -Use of anti-anxiety medications related to anxiety disorder. -Is on hypnotic therapy related to insomnia. -Uses antidepressant medication related to depression. Record review of an Order Summary Report dated 06/23/2025 for Resident 42 revealed: -Ambien 5 milligram (MG) give 1 tablet every bedtime for insomnia, order date 08/30/2024. -Klonopin 0.5 MG give ½ tablet 2 times a day for anxiety disorder, order date 06/05/2025. -Remeron 30 MG give 1 tablet every bedtime for Bipolar, order date 08/30/2024. -Seroquel 25 MG give 1 tablet 2 times a day for Bipolar, order date 08/30/2024. Record review of Resident 42's Medication Administration Record and progress notes for March 2025, April 2025, and June 2025 revealed no missed doses for all scheduled medication administrations. Record review of Resident 42's behavior monitoring and progress notes from dates 02/24/2025 through 06/25/2025 revealed behaviors occurred on several days, the behaviors documented stated: expressed frustration/anger towards others and cursing at others. Interventions documented revealed the behaviors were better or unchanged. Record review of the electronic health record (EHR) for Resident 42 revealed that it contained no documentation that the resident or family were informed of the risks, benefits, or alternative treatments for the use of the antipsychotic medication Seroquel. An interview on 06/25/2025 at 12:08 PM the Minimum Data Set Coordinator (MDSC) confirmed that the facility did not have documentation of resident/family education on risks, benefits, or alternate therapy regarding Resident 42's antipsychotic use.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Licensure Reference Number 175 NAC 12-006.09(D) Based on record review and interview, the facility failed to ensure psychotropic medications had approved indications for use for 2 (Residents 58 and 42) of 5 sampled residents. The facility census was 62. Findings are: A. Record review of a facility policy titled Antipsychotic Medication Use dated March 2015 revealed a Policy Statement of: Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. The Policy Interpretation and Implementation revealed: 1. Resident will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 5. Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. The interdisciplinary team will: a. Complete a PASRR screening (preadmission screening for mentally ill and intellectually disabled individuals), if appropriate; or b. Re-evaluate the use of the antipsychotic medication at the time of admission and/or within two weeks (at the initial MDS assessment) to consider whether or not the medication can be reduced, tapered, or discontinued. c. Based on assessing the resident's symptoms and overall situation, the Physician will determine whether to continue, adjust, or stop existing antipsychotic medication. 6. Antipsychotic medication shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic Statistical Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia; b. Schizo-affective disorder; (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Schizophreniform disorder; d. Delusional disorder; e. Mood disorders (e.g., bipolar, depression with psychotic features, treatment refractory major depression); f. Psychosis in the absence of dementia; g. Medical illness with psychotic symptoms and/or treatment-related psychosis or mania (e.g., high dose steroids); h. Tourette's disorder; i. Huntington's disease; j. Hiccups (not induced by medications) or k. Nausea and vomiting associated with cancer or chemotherapy. 7. Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: a. The behavioral symptoms present a danger to the resident or others; AND: i. The symptoms are identified as being due to mania or psychosis; or ii. Behavioral interventions have been attempted and include in the plan of care, except in an emergency. 10. Antipsychotic medications will not be used if the only symptoms are one or more of the following: a. Wandering; b. Poor self-care; c. Restlessness; d. Impaired Memory; e. Mild anxiety; f. Insomnia; g. Inattention or indifference to surroundings; (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Sadness or crying alone that is not related to depression or other psychiatric disorders; i. Fidgeting; j. Nervousness; or k. Uncooperativeness. Record review of an admission Record dated 06/23/2025 for Resident 58 revealed an admission date of 02/17/2025, and diagnosis information revealing: -Neurocognitive disorder with Lewy bodies (a type of progressive dementia (a condition characterized by memory loss and judgment) that leads to a decline in thinking, reasoning and independent function). -Alzheimer's disease (most common form of dementia). -Anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). -Insomnia (sleep disorder where people have difficulty falling asleep, staying asleep, or experience non-restorative sleep, despite having adequate opportunity for sleep). Record review of a Care Plan Report with a revision date of 06/03/2025 for Resident 58 revealed: -Uses antidepressant medication related to insomnia diagnosis and depression diagnosis. -Uses psychotropic medications related to disease process (Lewy body dementia). Record review of an Order Summary Report dated 06/23/2025 for Resident 58 revealed: -Donepezil (used to treat dementia associated with Alzheimer's disease) 5 milligram (MG) 1 tablet by mouth every day for Alzheimer's Disease, order date 04/14/2025. -Mirtazapine (an antidepressant medication used to treat major depressive disorder) 15 MG 1 tablet by mouth every day for depression and insomnia, order date 05/13/2025. -Seroquel (an antipsychotic that treats schizophrenia and bipolar disorder) 25 MG by mouth 2 times a day for dementia related to neurocognitive disorder with Lewy bodies, order date 02/17/2025. Record review of Resident 58's Medication Administration Record for June 2025 revealed no missed doses for scheduled medication administration. Record review of behavior monitoring and progress notes from dates 02/23/2025 through 06/24/2025 revealed behaviors occurred on several days, the behaviors documented stated: sad, tearful, neglecting self, wandering, entering other rooms, pacing, anxious and restless. Interventions documented stated: reapproach, redirection, one on one, and meaningful activities with mixed reviews or improvement and/or no change, unchanged behaviors. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 06/25/2025 at 12:08 PM with the Minimum Data Set Coordinator (MDSC) confirmed that Resident 58 is taking the medication Mirtazapine for depression, yet there is no diagnosis of depression in their medical health record or listed on the active diagnosis sheet for Resident 58. B. Record review of an admission Record dated 06/23/2025 for Resident 42 revealed an admission date of 05/16/2023, and diagnosis information revealing: -Unspecified dementia, unspecified severity, with other behavioral disturbance (characterized as agitation including verbal and physical aggression). -Bipolar disorder (mental health condition characterized by extreme shifts in mood, energy, and activity levels, causing significant disruptions in daily life). -Personal history of other mental and behavioral disorders. -Anxiety disorder Record review of a Care Plan Report with a revision date of 11/04/2024 for Resident 42 revealed: - Has potential to be verbally aggressive related to dementia, ineffective coping skills, mental /emotional illness, diagnosis (dx) of Bipolar and a history of alcohol abuse. -Impaired cognitive function related to dx of dementia, history of alcohol use in remission, dx of bipolar as evidenced by impaired decision making. -Use of psychotropic medication related to dx and history of Bipolar. -Use of anti-anxiety medications related to anxiety disorder. -Is on hypnotic therapy related to insomnia. -Uses antidepressant medication related to depression. Record review of an Order Summary Report dated 06/23/2025 for Resident 42 revealed: -Ambien 5 milligram (MG) give 1 tablet every bedtime for insomnia, order date 08/30/2024. -Klonopin 0.5 MG give ½ tablet 2 times a day for anxiety disorder, order date 06/05/2025. -Remeron 30 MG give 1 tablet every bedtime for Bipolar, order date 08/30/2024. -Seroquel 25 MG give 1 tablet 2 times a day for Bipolar, order date 08/30/2024. Record review of Resident 42's Medication Administration Record for June 2025 revealed no missed doses for scheduled medication administration. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of behavior monitoring and progress notes from dates 02/24/2025 through 06/25/2025 revealed behaviors occurred on several days, the behaviors documented stated: expressed frustration/anger towards others and cursing at others. Interventions documented revealed better or unchanged. An interview on 06/25/2025 at 12:08 PM the Minimum Data Set Coordinator (MDSC) confirmed that Resident 42 is taking a medication Ambien for insomnia, yet there is no diagnosis of insomnia in their medical health record or listed on the active diagnosis sheet for Resident 42.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview the facility failed to notify the ombudsman (a state appointed advocate for residents of nursing homes) of resident discharge for 1 of 1 residents reviewed (Resident 63) as required. The facility census was 62. Findings are: Record review of the facility policy titled Discharge Planning Process dated 5/3/17 revealed that the facility will develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of the resident to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The Discharge Checklist section of the policy revealed that the facility will notify the ombudsman of resident discharge by fax on the date of discharge. Record review of the discharge Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) for Resident 63 dated 4/1/25 revealed that Resident 63 admitted into the facility on 2/28/25. The MDS revealed that Resident 63 had a discharge date of 4/1/25. Interview on 6/25/25 at 10:46 AM with the facility Social Services Director (SSD) revealed that the SSD was unsure if anyone in the facility notifies the ombudsman of resident discharges or transfers. The SSD revealed that they would find out. Interview on 6/25/25 at 11:10 AM with the SSD revealed that the Director of Nursing Services (DNS) is the facility staff that gives notifications of transfers and discharges to the ombudsman. Interview on 6/25/25 at 3:39 PM with the facility Director of Nursing Services (DNS) confirmed that the facility only notifies the ombudsman of resident transfers to the hospital. The DNS confirmed that they do not notify the ombudsman of resident discharges from the facility. The DNS revealed that the DNS documents the facility ombudsman notifications on the Record of Transfers/Discharges form. This surveyor requested the Record of Transfers/Discharges forms from August 2024 to current date. Record review of the provided facility Record of Transfers/Discharges dated from 8/2/24 through 6/23/25 revealed no documentation of ombudsman notification of the discharge of Resident 63. Interview on 6/26/25 at 8:52 AM with the facility DNS confirmed that the facility did not notify the ombudsman of the discharge of Resident 63 on 4/1/25 as required.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Licensure Reference Number 175 NAC 12-006.09(A)(i) Based on record review and interview the facility failed to ensure that a Preadmission Screening and Resident Review (PASARR) Nebraska Level 1 Form (an initial pre-screening for mental illness and intellectual/developmental disabilities prior to admission) screening was completed prior to resident admission into the facility for 1 of 5 sampled residents (Resident 34). The facility census was 62. Findings are: Record review of the facility policy titled Resident Assessment-Coordination with PASARR Program dated 2/4/22 revealed that the facility coordinates assessments with the preadmission screening and resident review (PASARR) program to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. All applicants to the facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. PASARR Level 1- is the initial prescreening that is completed prior to admission. The facility will only admit individuals with a mental disorder or intellectual disability who the state mental health authority has determined as appropriate for admission. A record of the pre-screening will be maintained in the resident's medical record. Exceptions to the pre-admission screening program include those individuals who are re-admitted directly from a hospital; and individuals who are admitted directly from a hospital and has been certified by the attending physician that the individual is likely to require less than 30 days of nursing facility services. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. Record review of the admission Record for Resident 34 dated 6/24/25 revealed that Resident 34 admitted into the facility on 7/15/24. The admission Record revealed that Resident 34 admitted into the facility from another nursing home and had diagnoses of Post Traumatic Stress Disorder; Anxiety; Depression; and Unspecified Psychosis (a diagnosis given when a person experiences psychotic symptoms like hallucinations or delusions). Record review of the medical record for Resident 34 revealed that it contained a completed Level 1 PASSAR evaluation for Resident 34 dated 5/4/23 (over 14 months prior to admission to the facility). The record did not contain a PASSAR Level 1 screen within 30 days prior to or after the admission to this facility on 7/15/24. Interview on 6/26/25 at 8:52 AM with the facility Social Services Director (SSD) confirmed that the facility did not request a current PASARR level 1 screen for Resident 34 prior to admission as required. The SSD confirmed that the PASARR level 1 dated 5/4/23 was the level 1 evaluation for admission to the nursing home where Resident 34 resided prior to coming to this facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Licensure Reference Number 175 NAC 12-006.09(E) Based on record review and interview, the facility failed to review and revise the comprehensive care plan with new interventions after each fall for one (Resident 15) of one resident sampled. The facility census was 62. Findings are: Record review of the facility policy Comprehensive Care Plans dated 10/18/2017 revealed under Policy Explanation and Compliance Guidelines, paragraph 6 that the comprehensive care plan will be prepared by an interdisciplinary team that includes but is not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, the resident and the resident's representative to the extent possible, and other appropriate staff. Alternative interventions will be documented, as needed. Paragraph 10 stated staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. Record review of an Incident Report printed 06/24/2025 revealed Resident 15 had an unwitnessed fall on 06/19/2025 and a second unwitnessed fall on 06/23/2025. Record review of the comprehensive care plan for Resident 15 dated 06/24/2025 revealed Resident 15 was at risk for falls. The last update to the care plan related to falls was completed on 05/17/2025. No further interventions or goals had been added for falls since that date. In an interview on 06/24/2025 at 2:40 PM with Registered Nurse (RN)-I who stated that the only persons that update the comprehensive care plans are the Director of Nursing Services (DNS) and the Minimum Data Set Coordinator (MDSC). RN-I was unsure if anyone else had access to update the care plans. In an interview on 06/24/2025 at 2:43 PM with RN-J confirmed that the only people that were able to update the comprehensive care plans or add to the working care plan was the DNS and the MDSC. In an interview on 06/25/2025 at 11:20 AM with DNS who revealed that the only persons that update the care plans are the DNS and MDSC and those are completed either the same day or the day after any fall or infection that is being treated. All other updates are completed as needed with resident assessments or after weekly risk meetings or meetings with staff or family. In an interview on 06/25/2025 at 2:05 PM with MDSC who confirmed that the working care plan and comprehensive care plan had not been updated until that day and not on the same day or the day after the fall incidents had occurred for Resident 15. the MSDC also confirmed that all falls and infections are to be updated on the comprehensive care plans either the same day or the day after the occurrence.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations, interviews, and record reviews; the facility failed to ensure meals were served within the allotted time frames set forth by the facility staff. This had the potential to affect all residents served from the kitchen. The facility census was 62. Findings were: Record review of the facility policy Serving of Meal Trays copyright date 2000, revealed there was no specific time frame in which meals had to be served but did state that hot foods should be hot when they reached the resident and cold trays should be cold. Record review of the mealtimes posted for the facility stated that lunch will be served at 12:00 PM. Interview on 06/23/2025 at 1:50 PM with Resident 42 who revealed that it isn't uncommon to have to wait an hour to be served for lunch and supper meals. Observation of the noon meal served on 06/24/2025 between the hours of 11:35 AM and 12:50 PM: Frequent observations were made of Cook-A standing and waiting to dish up more meals as Cook-A awaited the dietary staff who were serving meals to return with the meal carts which were used to carry the meals to the tables. At the table and prior to setting the plate on the table for each resident, the dietary staff would ask if the resident wanted any condiments with the meal. Dietary staff also donned gloves and deboned the chicken wings being served at the table while the other plates on the meal cart cooled. -11:35 AM some of the residents were already seated and were visiting with their table mates. -11:45 AM Dietary staff placed desserts and drinks at each table for individual residents. -11:55 AM there were many more seated at their tables in the dining room ready for the meal to be served. Many of the seated residents were eating their desserts and drinking their juices, milk, and water while awaiting the meal and visiting with their table mates. -12:03 PM the service window for meals was opened for the kitchen staff in preparation for the meal to be served. -12:13 PM Cook-A started serving meals. -12:14 PM dietary staff served 4 meals to the first table of 4 residents. -12:18 PM dietary staff served 1 meal to a table of one and 4 meals to a table of 4. -12:24 PM dietary staff served 3 meals to a table of 3 residents. -12:26 PM dietary staff served 2 meals to a table of 2 residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285270	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home, Inc	515 West First Street Minden, NE 68959

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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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-12:30 PM two dietary staff served 4 meals to a table with 4 residents, 1 meal to a table with 1 resident, and 2 meals to a table with 2 residents. -12:34 PM dietary staff served 4 meals to a table with 4 residents. -12:35 PM dietary staff served 3 meals to a table with 3 residents. -12:40 PM dietary staff served 4 meals to a table with 4 residents. -12:44 PM dietary staff served 4 meals to a table with 4 residents, and 2 meals to a table with 2 residents. -12:45 PM one resident was removing their clothing protector and was ready to go back to their room. This resident told the Nursing Assistant they were ready to go back to the room when the nursing assistant approached. The nursing assistant (NA) removed the clothing protector from the resident and started to take the resident back to the resident room, but the NA was stopped when told that this table had not yet been served the noon meal. Resident had eaten the dessert and finished the drinks placed before her. -12:47 dietary staff served the last table of four residents their four meals to the table where the resident had tried to leave. -12:52 room trays for 4 residents were prepared and given to nursing staff for meal delivery. Interview on 06/25/2025 at 10:05 AM with Cook-A who stated that the mealtime was long the day before as the staff had to remove the bones from some of the food before it was served. Interview with the Dietary Manager (DM) on 06/25/2025 at 12:35 PM revealed that the staff have been given instructions that all meals must be served within 30 minutes of the time meals begin. Hot meals are to be served hot and cold meals are to be served cold. Temperatures of foods are to be taken prior to meal service to ensure that foods being served are hot enough and follow the food code. The facility does have a policy about food trays, but the required time is not written. However, all personnel are trained to have meals served in 30 minutes. Each table is rotated as to which one gets to be served first. The rotation is with each meal and not a daily rotation. The staff felt this was fair to all residents as to who is served first. At 11:55 AM there were many more seated at their tables in the dining room ready for the meal to be served. Confirmed that taking such a long time to serve meals the day before was not acceptable. Confirmed that dietary staff have to take time to cut up many of the foods prior to setting the foods on the table, or in the case of the day before remove the bones and that takes time. Confirmed the staff are supposed to have all meals delivered and on the tables within 30 minutes. Interview on 6/25/2025 at 2:35 PM with the Facility Administrator who confirmed the mealtimes are 8:00 AM for Breakfast, 12:00 PM for the noon meal, and 6:00 PM for the evening meal.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 12-006.11(A) Based on record review, interview, and observation, the facility failed to ensure that all individuals with beards and moustaches wore beard and moustache coverings, and the facility failed to ensure a safe and effective cleaning routine and process for changing the filtration system of the facility ice machine. This had the potential to affect all residents residing in the facility. The Census was 62. Findings are: A. Record review of the Policy for Hair Nets and Facial Hair last reviewed on 01/20/2026 revealed that everyone working in the dietary department must be cleanly shaved (this does not include eyebrows or eyelashes). The procedure section revealed staff must be clean shaven, no one or two-day growths without wearing a beard guard or mask that covers the whole area. Observation on 06/23/2025 at 8:30 AM revealed the Cook-A who was serving the breakfast meal had on a hair net but did not have a beard and moustache covering in place. Observation on 06/24/2025 at 8:15 AM revealed that Cook-A was not wearing a beard and moustache covering while serving breakfast. Observation on 06/24/2025 at 12:05 PM revealed Cook-A and Cook-B did not have on a beard and moustache covering. Cook-A was serving the noon meal and Cook-B was in the kitchen area. Observation on 06/24/2025 at 12:30 PM revealed Cook-A and Cook-B both stopped working to put on a beard and moustache covering before continuing to work in the kitchen. Interview on 6/24/2025 at 2:05 PM with Cook-B who revealed not wearing beard covering the entire time while working in the kitchen but did stop to put one on. [NAME] B stated that they were a new hire and were still learning. Interview on 06/25/2025 at 10:10 AM with Cook-A confirmed they had not worn a beard and moustache covering at all times while working in the kitchen. B. Observation on 06/24/2025 at 11:10 AM of the facility ice machine which had dates on the four filters. One filter was in a clear (transparent) container, was dark brown in color with small particulates on the filter, and had a date of October 2024 written on the outside of the canister. There were three more filters in blue opaque that had dates written on them. Those dates were 5/13/2019, 7/24/2020, 9/21/2021, 5/26/2022, and 1/13/2023. The area of the ice machines where one can sit a glass or a pitcher to be filled with ice had what looked to be multi colored brown, grey, and white mineral deposits and rust. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Dietary Manager on 6/24/2025 at 12:35 PM revealed that maintenance is in charge of cleaning and caring for the ice machines located within the facility. Interview on 06/24/2025 at 3:20 PM with Maintenance Personnel (Maint)-F revealed that the ice machines are an enclosed system and must be cleaned thoroughly on a yearly basis. Filters for the 4 filters in the ice machine water line system had to be changed on a regular basis. Maint-F did not have a policy but knew that the lines had to be changed every 6 months for the transparent filter and every year for the other three filters in the system. Maint-F confirmed the filters needed to be changed and the old dates needed to be removed from the filters with an alcohol swab with a new date added. Interview on 06/24/2025 at 3:23 PM with Maint-G confirmed that the filters had to be changed every 6 months for the transparent filter and every year for the opaque blue filters. Maint G confirmed that the filters had not been changed in the 6 month and yearly interval as is required by the staff. Maint-G also revealed not being aware of any written policy related to the filtration system. Interview on 06/24/2025 at 3:40 PM with Maint-F who looked for policies pertaining to the filtration system of the ice machine and that there was no manual found. Interview on 06/24/2025 at 4:15 PM with the facility Administrator (ADMIN) confirmed that the daily cleaning of the ice machines needed to be done by the dietary or housekeeping department. ADMIN further confirmed that the ice machines did have mineral buildup on the service area and that a new base where the cups and pitchers sit to be filled with ice would be ordered because it was starting to rust and didn't look like it could be easily cleaned.