

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555924	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2025
NAME OF PROVIDER OR SUPPLIER Bethel Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2280 Dockery Avenue Selma, CA 93662	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide care in a manner that maintained dignity and respect for one of three sampled residents (Resident 1), when Resident 1 was awoken at 2:00 a. m. and subjected to two attempted straight catheterizations (invasive thin flexible tube used to drain urine from the bladder) without a physician order or consent. This failure violated the resident's rights to receive care in a dignified and respectful manner. During a review of Resident 1's admission Record (AR) dated 8/22/25, the AR indicated, Resident 1 was initially admitted to the facility on [DATE] with diagnoses of hemiplegia (the loss of the ability to move one side of the body), Metabolic encephalopathy (brain dysfunction, which disrupts normal brain function) and malignant neoplasm of brain (a cancerous growth in the brain or central nervous system). During a review of Resident 1's Order Summary Report (OSR) dated 8/8/25, at 1307 the OSR indicated, .May have UA (urinalysis medical test that examines urine to help diagnose medical conditions). One time only for foul order for 3 days. During a review of Resident 1's OSR dated 8/10/25 at 0305 the OSR indicated .May have UA with C&S (culture and sensitivity a more detailed test of the urinalysis indicates a possible infection) if indicated one time only for foul odor for 3 days. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 6/24/25, the MDS section C indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 1 was cognitively intact. During an interview on 8/22/25 at 8:50 a.m. with Resident 1's sister who is also the Responsible Party (RP) for Resident 1, the RP stated on 8/8/25 the facility informed her of Resident 1 having foul smelling urine and suspected UTI (infection of the urinary tract). The facility also informed her a urine sample was needed for a UA. The RP stated Resident 1's urine sample was obtained by a hat (a common term for a medical device that fits over the toilet bowl to collect urine). The RP stated on 8/11/25, RP made a daily visit to see Resident 1 and Resident 1 became visibly upset when explaining in detail about a nurse coming into Resident 1's room in the middle of the night and inserting a straight catheter into her urethra (a short tube in females that connects the bladder to the external genitals, serving as the pathway for urine to exit the body). During an interview on 8/22/25 at 10:23 a.m. at nurses' station on C wing, with Licensed Vocational Nurse (LVN) 2, LVN 2 stated a physician order was needed to obtain a UA. LVN 2 stated UA collection methods included urinating into a hat that was placed over the toilet or by straight catheterization. LVN 2 stated once the UA is collected a label is placed on the specimen then the specimen is placed within the fridge and laboratory was notified. LVN 2 stated if an additional UA specimen was required a new physician order would be required with method for collection. During a concurrent observation and interview on 8/22/25 at 11:39 a.m. with Resident 1, Resident 1 was observed coming from her restroom. Resident 1 stated she had used the restroom. Resident 1 recalled the nurse who had entered her room on 8/10/25 at 2:00 a.m. and stated another urine sample was needed. Resident 1 mentioned she was very confused and too nervous to ask questions, when the nurse began preparing the items for catheterization, especially since she had been able to use the hat for the first urine sample that was collected. During a phone interview on 8/27/25 at 3:44 p.m. with LVN 1, LVN 1 indicated on 8/10/25 she had entered Resident 1's room around 2:00 a.m. and woke Resident 1 up to collect a urine sample from Resident 1. LVN 1 stated around 2:00 a.m. was the normal time for brief checks and changing of residents, LVN 1 stated she felt it was a good time to collect the sample. LVN 1 used a straight catheter for the urine sample collection of Resident 1. LVN 1 stated she went into Resident 1's room alone and did not ask for help going into the room, because LVN 1 was able to perform a straight catheterization on residents who are alert such as Resident 1. LVN 1 stated she performed two attempts at inserting the catheter into Resident 1's urethra with failed attempts. LVN 1 stated after the failed attempts she had Resident 1 urinate into a bedpan, and the sample was collected. LVN 1 stated she did not contact the physician to obtain an order and there was no order for the straight catheter. During a phone interview on 8/26/25 at 1:05 p.m. with the DON, the DON acknowledged LVN 1 had attempted to perform a straight catheterization on Resident 1 without a physician's order and without obtaining consent from Resident 1's RP. The DON stated straight catheterization is considered an invasive procedure, and it was not the facility's expectation for staff to perform such a procedure without</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure physician orders were followed for 1 of 3 sampled residents (Resident 1). When the Licensed Vocational Nurse (LVN) 1 obtained a urine specimen by straight catheterization (invasive thin flexible tube used to drain urine from the bladder) without a physician order for catheter. This failure had the potential to place the resident at risk for unnecessary pain, infection, and psychosocial harm. During a review of Resident 1's Order Summary Report (OSR) dated 8/8/25, at 1307 the OSR indicated, .May have UA (urinalysis medical test that examines urine to help diagnose medical conditions). One time only for foul order for 3 days. During a review of Resident 1's OSR dated 8/10/25 at 0305 the OSR indicated .May have UA with C&S (culture and sensitivity a more detailed test of the urinalysis indicates a possible infection) if indicated one time only for foul odor for 3 days. During a review of Resident 1's admission Record (AR) dated 8/22/25, the AR indicated, Resident 1 was initially admitted to the facility on [DATE] with diagnoses of, hemiplegia (the loss of the ability to move one side of the body), Metabolic encephalopathy (brain dysfunction, which disrupts normal brain function) and malignant neoplasm of brain (a cancerous growth in the brain or central nervous system). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 6/24/25, the MDS section C indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 1 was cognitively intact. During a concurrent observation and interview on 8/22/25 at 11:39 a.m. with Resident 1, Resident 1 recalled the nurse who had entered her room on 8/10/25 at 2:00 a.m. and informed her another urine specimen was needed. Resident 1 stated she was very confused and too nervous to ask questions, when the nurse began preparing the items for catheterization, since she had previously been able to provide a urine specimen using a hat. During a phone interview on 8/27/25 at 3:44 p.m. with LVN 1, LVN 1 indicated on 8/10/25 she had entered Resident 1's room around 2:00 a.m. and attempted to insert a straight catheter two times without success. LVN 1 stated after two failed attempts she obtained a urine specimen by having Resident 1 void into a bedpan. LVN 1 stated she did not notify the physician for an order and did not notify the responsible party before attempting the straight catheterization. LVN 1 Further indicated she was unaware this practice was unacceptable because it was the standard procedure for obtaining a urine sample at her previous place of employment, for residents who are incontinent (lack of voluntary control over urination) . During a phone interview on 8/26/25 at 1:05 p.m. with the Director of Nursing (DON), the DON stated LVN 1 had attempted to perform a straight catheterization on Resident 1 without a physician's order. The DON stated straight catheterization is considered an invasive procedure, and it was not the facility's expectation for staff to obtain a physician order prior to performing such procedure. During an interview on 8/22/25 at 12:01 pm with the Administrator, the Administrator acknowledged LVN 1 was wrong to attempt a straight catheterization on Resident 1 without a physician order, and it was facility's expectation all staff follow physician orders, adhere to facility policy, and document all interactions and communications. During a review of the facility's policy and procedure (P&P) titled, Cultures, Specimen Collection, dated 10/11, the P&P indicated, .Procedure guidelines. Explain the procedure completely to the resident. Urine culture from indwelling catheter 1. Validate the physician's order. During a review of the facility's P&P titled, Indwelling (foley) Catheter Insertion, Female Resident, dated 8/22, the P&P indicated .2. Verify that there is a physician's order for this procedure. Documentation. The indication. how the resident tolerated the procedure. During a review of the facility's P&P titled, Clean Catch Urine Specimen, dated 10/10, the P&P indicated .Verify that there is a physician's order for this procedure. Equipment and Supplies. Bedpan/urinal (if resident is unable to leave bed) . During a review of the facility's P&P titled, Resident Rights Guidelines for All Nursing Procedures, dated 10/10, the P&P indicated .If the resident is sleeping, and the procedure is not urgent or scheduled, return when the resident is awake. During a review of the facility's P&P titled, Medication and Treatment Orders, dated 7/16, the P&P indicated .orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and time of the order.</p>		