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 _____	C 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY LUTHERAN HOME	SEVEN ELLIOTT STREET COUNCIL BLUFFS, IA 51503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 12-22-21 The following deficiencies relate to the investigation of complaints: 90477-C, 92266-C, 94717-C, 95012-C, 96000-C, 96434-C, 97328-C, 99473-C, and 100254-C, and facility reported incidents 92298-I, 95854-M, 99146-I, 99453-I, 99692-I, 100109-I, 100449-I conducted by the Department of Inspections and Appeals on 10/28/21-12/1/21. Complaints 90477-C, 92266-C, 94717-C, 95012-C, 96000-C, 96434-C, 97328-C, 99473-C, 100254-C, and facility reported incidents 92298-I, 99146-I, 99453-I, 99692-I, 100109-I, and 100449-I were substantiated. Findings for facility reported incident 95854-M will be sent to the facility at a later date under separate cover. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	Correction Date is December 22, 2021 1. To correct this deficiency as it relates to resident #21, on 12-8-21 the Director of Nursing revised a resident-specific assigned task in PointClickCare (facility EMR) to reflect the resident's request so that all overnight aides would be aware. This task initiates from PointClickCare and populates to Point of Care CNA documentation and states "Awaken and offer toileting assistance at 1am and 5am at my request." CNAs must now document incontinence cares provided at those specific times. The DON educated staff during in-servicing beginning 12/17/21 on resident #21's specific incontinence care request. To correct this deficiency as it relates to residents #1, #16, and #18, education was provided to nursing staff during the Nursing Staff Meetings beginning 12/17/21 to transfer and assist residents in a kind and considerate manner. (See attached "Nursing Staff Education Complaint Survey 2021".) To correct this deficiency as it relates to resident #24, on 12/1/21 the Director of Nursing ensured that the resident had a dignity bag in place covering the urinary drainage bag and educated staff on the unit that the resident must have the dignity bag in place unless actively emptying the urinary drainage bag.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, and grievance and policy review, facility staff failed to assist 1 of 3 residents reviewed, (Resident #21) with incontinence care when she requested it of them, which caused her to lay in a urine-soaked bed. The facility also failed to transfer and assist residents in a kind and considerate manner for 3 of 5 residents reviewed (Residents #1, #16 and #18) for transfer	F 550	2. To protect other residents in similar situations, education was provided to nursing staff beginning on 12/17/21 (see attached "Nursing Staff Meeting" announcement for dates/times.) The Director of Nursing instructed staff to provide incontinence care to all residents as they request, to transfer and assist residents in a kind and considerate manner, and to provide a dignity bag for all urinary drainage bags. (See attached "Nursing Staff Education Complaint Survey 2021") 3. To ensure the problem does not recur, the Director of Nursing or designee will perform weekly audits using the Weekly Dignity Bag/Catheter Audit form (see attached) and the Transfer and Incontinence Care Audit form (see attached) for a minimum of three months.	

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F 550	Continued From page 2 and repositioning assistance, and did not protect Resident #24's dignity when staff failed to provide a dignity bag to cover her catheter drainage bag. The facility reported a census of 89 residents. Findings include: 1. The Minimum Data Set (MDS) dated 1/4/21 for Resident #1 identified a Brief Interview of Mental Status (BIMS) score of 15. A score of 15 indicated no cognitive impairment. The MDS revealed the resident required extensive assistance of two staff for bed mobility, dressing, toilet use and personal hygiene and was total dependent of staff for transfers. The MDS documented diagnoses that included: anemia, heart failure, hypertension, renal failure, pneumonia, and rhabdomyolysis (muscle breakdown). The Care Plan focus area dated 12/29/2020 indicated Resident #1 had activities of daily living (ADL) self-care performance deficit due to weakness. The Care Plan provided the resident required assistance of two staff for stand to pivot transfers. Review of the facility's grievances revealed the following grievance dated 2/3/21: Resident #1 reported to the Social Worker/Compliance Officer on 2/3/21, she was having pain in the evening and when asked for Staff A Certified Nursing Assistant (CNA) to move her to the recliner, she refused. Staff A stated she was a liar and lying about the pain. The resident stated the CNA told her that if you don't shut your mouth we are going to shut the door and not answer your call light. Resident stated she was scared. The	F 550	4. To monitor performance and to ensure solutions are permanent, audits will be reported to the QAPI Committee for 3 months. The QAPI Committee will then determine if further reporting and/or monitoring is to continue. The Director of Nursing or designee will meet with interested cognitively intact residents for a " DON & Coffee" activity every two weeks for a minimum of three months. During this activity, the Director of Nursing or designee will discuss with residents to ensure that they feel they are being transferred and assisted in a kind and considerate manner.	

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F 550	Continued From page 3	F 550		

grievance/concern was given to Staff B previous Director of Nursing (DON) for further investigation. The grievance form had the following in the investigation summary portion: the DON interviewed the resident and confirmed the description of the CNA. The resident stated the staff member called her a liar multiple times and stated her contract was up in 27 days and could not wait to be done with this facility. The facility ended the CNA's contract with them. The form was signed and dated by Staff B on 2/3/21.

Review of the facility investigative file revealed the following summary: Staff B went in to the resident's room on 2/3/21 and introduced herself to the resident. Staff B asked her how her stay at facility had been. Resident #1 stated that last night was not good. She stated that her air mattress had deflated and was hitting the rails causing her back to hurt. She stated she had tried to alleviate the pain herself by repositioning, pushing her feet/buttock to move herself in the bed. When she could no longer take the pain she turned on her call light to ask the CNA for assistance into her recliner. The resident stated that she accused her of not telling the truth and called her a liar multiple times. Also stated the CNA had mentioned that she had 27 days left and could not wait to get out of here. When Staff B asked the resident to describe the CNA she was referring to, she described her as a black female. The Staff B asked if she had problems with any other staff members, she stated just her. When asked how the other CNA caring for her was, as there were two aides working that station, she stated she was very nice. When asked if she was afraid of our staff she stated just that CNA that was calling her a liar. The resident requested several times during the interview to not have

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F 550	Continued From page 4	F 550		

Staff A return to her room or work her hall. Interview ended at that time. After talking with the resident, the Staff B called and spoke with the other CNA that was on that evening who stated she was not aware of any incident and did not notice any neglect during her shift.

On 11/10/21 at 12:16 PM Staff B stated she was able to speak of the incident that occurred. She stated Resident #1 was very with it at the time of the incident. She provided during the investigation the resident's story never changed. She indicated Resident #1 reported her air mattress was having issues with staying inflated; felt like she was sinking in the center of the bed. She asked Staff A to assist her to her recliner and that was when Staff A told the resident she was not having pain, was lying and was not going to move her. Staff B was asked if the resident mentioned any names during her investigation, she indicated the resident described her as a person of color. When asked if the resident mentioned if any other staff members were in the her room at that time, Staff B stated the resident stated later in the evening there were other staff in her room but when the incident took place it was just herself and Staff A. Staff B provided she followed up with the resident after ending Staff A's contract to see how things were going, she stated they were fine and things were great. Staff B stated the resident has never voiced concerns like this prior to the incident.

On 11/23/21 at 9:32 AM the Social Worker/Compliance Officer stated when the concerns are brought to her, she would get the appropriate departments involved. When asked about her involvement with this concern she stated she was there to support and advocate for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 5	F 550		

the resident. She wanted to make sure her needs were being met. Resident #1 reported to her that a staff member (She did not mention any names) told her to shut her mouth, they were going to shut her door and not answer her call lights. The resident did report she was scared and that prompted the Social Worker/Compliance Officer to report the concerns.

On 11/30/21 8:32 AM Staff A stated there were two other staff members in Resident #1's room when she was complaining for pain. When asked who those staff members were she stated another CNA and a male Certified Medication Aide (CMA); she could not remember their names. She provided there are cameras in the facility and they are able to pull them up to see there were three staff members that entered her room. When they entered the resident's room, the resident had requested a pain medication but it was too early for her to receive one. Staff A denied calling the resident a liar, telling her they would not answer her call lights.

On 12/1/21 at 7:41 AM the Director of Nursing (DON) stated residents should be treated with dignity and respect at all time. She added this is their home and they are their visitors.

The facility policy titled Quality of Life-Dignity revised 2/2020 provided each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Residents are treated with dignity and respect at all times.

2. The Minimum Data Set (MDS) assessment dated 10/22/21 for Resident #16 identified a Brief

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F 550	Continued From page 6 Interview of Mental Status (BIMS) score of 15. A score of 15 indicated no cognitive impairment. The MDS documented she required extensive assistance of 2 staff for bed mobility, extensive assistance of 1 staff for transfers and toilet use. The MDS documented diagnoses that included: coronary artery disease, heart failure, diabetes mellitus, depression, sleep apnea, and chronic obstructive pulmonary disease (COPD). The Care Plan focus area dated 10/22/21 identified the resident had a lifestyle change that resulted in the admission to the nursing home. On 11/9/21 at 10:00 AM during a confidential group interview, one of the residents stated she had issues with staff being really tough and harsh; she felt as if they "flopped" her into bed. She stated she reported her concerns to management at the time and they took care of it. When asked if she knew the staff person's name, she replied she did not wish to disclose that information. 3. The MDS assessment dated 10/27/21 for Resident #18 identified a BIMS score of 15. A score of 15 indicated no cognitive impairment. The MDS documented she required extensive assistance of 2 staff for bed mobility, transfers, and toilet use. The MDS documented diagnoses that included: atrial fibrillation, heart failure, renal failure, anxiety, depression, respiratory failure, and sleep apnea. The Care Plan focus area dated 4/14/21 identified the resident had self-care performance deficit related to recent hospitalization for acute kidney failure. The Care Plan interventions included: staff are to assist with bed mobility, she wears	F 550		

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F 550	Continued From page 7 adult briefs, ensure peri cares are done routinely. Review of the facility's grievances revealed the resident had filed a grievance on 6/16/21: staff had wiped the resident roughly after being asked to wipe her gently. The staff member continued to wipe roughly and claimed she did not hear the resident. The resident stated it hurts so much. The staff member left the room and the other CNA continued to provide care for the resident alone. The grievance form documented the staff member in question ended her contract with the facility prior to the investigation. On 11/9/21 at 11:01 AM Staff C CNA provided she had heard some complaints of other staff members being rough and hurried with residents during cares. On 11/9/21 at 11:20 Staff J Certified Medication Aide (CMA)/Staffing Coordinator reported residents expressed concerns with staff being rough during transfers and getting up to go to the restroom. She elaborated and stated the staff members were rushed. The residents reported to her that they were never hurt just felt rushed and unsafe. During a follow up interview on 11/23/21 at 9:25 AM she provided they let several staff go: 2 CNAs and a nurse. Residents complained about being rushed with cares so they moved the CNA to a different hall and the complaints continued so they terminated her, one resident that complained was Resident #16. They let another CNA go because she was not meeting the needs of the residents by not putting them to bed when they wanted. The nurse was let go because she was inconsiderate of a resident's feelings and very short with other residents.	F 550		

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F 550	Continued From page 8 On 11/9/21 at 2:21 PM Staff N CNA indicated he never witnessed other staff members being rough with resident but residents have reported staff being rough when repositioning them in bed. He believed it was the smaller female staff members that have to be more forceful to turn them because they lack strength. On 11/9/21 at 2:46 PM Staff O CNA stated she had witnessed some aides being rough with transfers and while turning residents in bed. She could not remember the staff or resident's names but she told Staff B about her concerns. On 11/23/21 at 10:01 AM the resident stated there was an agency CNA that was rough with her. She had a sore on her bottom and the CNA rubbed as hard as she could. The resident asked her why she was being rough, the staff member stated she did not hear her then left the room. She provided that staff member no longer works here. On 12/1/21 at 7:41 AM the Director of Nursing (DON) stated she has had no residents complain of staff members being rough with them nor has she terminated staff members related to being rough with residents. The DON was informed of staff reporting resident's concerns with other staff members being rough with transfers and cares; making them not feel safe. She replied "No, that goes back to treatment of residents with dignity and respect." She added even if it is not the staff's intention to make them feel that way, it's how the residents feel that matters. 4. The MDS assessment dated 11/9/21 for Resident #21 identified a BIMS score of 15. A score of 15 indicated no cognitive impairment.	F 550		

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F 550	Continued From page 9 The MDS documented the resident required extensive assistance of 2 staff for bed mobility, transfers, toilet use and personal hygiene. The MDS documented diagnoses that included: coronary artery disease, renal failure, diabetes mellitus, sleep apnea, and COVID-19. The Care Plan focus area dated 7/15/21 identified the resident was at risk for incontinence because of diuretic use, diagnosis of overactive bladder and impaired mobility. The Care Plan interventions included: she required total staff assistance for peri-cares and brief changes. She has requested to be checked around 1:00 AM and 5:00 AM during the night so she can sleep. Review of the facility's grievances revealed the resident had filed a grievance on 10/18/21: she gets changed every night at 1:00 AM, then she is supposed to get changed at 5:00 AM. The overnight CNA never comes in for her 5:00 AM change. This happens every night that CNA works on her hall. The resident stated she wakes up soaked in her own urine and needing a complete bed change. On 11/23/21 at 10:22 AM the resident stated she has a prolapsed urethra and likes to be changed at 1:00 AM and 5:00 AM but it is not getting done. She indicated when she does not get changed at 5:00 AM her bed will be soaked in urine to the point it drips off of her bed. When asked how often this happens, she stated it all depends on who is working that night. On 12/1/21 at 7:41 AM the DON provided Resident #21 had voiced concerns with her about not getting checked on at 5:00 AM and she did speak with the overnight nurse about this. She	F 550		

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F 550	Continued From page 10 provided the resident is very specific regarding timeframes associated with her schedules and requests. If staff show up at 5:30 AM to complete her cares she will report it is not getting done like she asked. She added staff do their best to accommodate this but does not always happen. 5. The MDS assessment dated 10/21/21 for Resident #24 identified moderately impaired cognitive skills for daily decision making. The MDS documented she had an indwelling catheter (drainage tube to drain the bladder). The MDS documented the following diagnoses: heart failure, renal failure, neurogenic bladder, respiratory failure, and polyneuropathy. The Care Plan focus area dated 10/27/21 documented she had an indwelling catheter. Observation on 11/23/21 at 10:51 AM revealed the resident was lying in bed. The resident's catheter bag was secured to her bed with no dignity bag covering the drainage bag. The uncovered drainage bag could be seen as one walked passed her room, as the bag faced the door way to the hall. Follow up observation on 11:30 AM revealed a dignity bag was placed on her catheter drainage bag. On 12/1/21 at 7:41 AM the DON stated the urinary drainage bags should have a dignity bag on at all times unless the resident refuses. The facility policy titled Quality of Life-Dignity revised 2/2020 provided staff are expected to help residents keep their urinary catheter bags covered.	F 550		
F 677 SS=E	ADL Care Provided for Dependent Residents	F 677		

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F 677	Continued From page 11 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, resident council interview and facility policy review the facility failed to provide adequate bathing opportunities for 7 of 7 residents reviewed (Resident #17, 18, 19, 20, 21, 22, and 23). The facility reported a census of 89 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated 11/11/21 for Resident #17 identified a Brief Interview of Mental Status (BIMS) score of 15. A score of 15 indicated no cognitive impairment. The MDS documented he required physical help limited to transfer only of two staff for bathing. The MDS documented diagnoses that included: type 2 diabetes mellitus, coronary artery disease, obesity, and sleep apnea. Review of Nursing Staff 24 hour Shift Report form 8/21/21-11/19/21 revealed the following; it listed what residents needed showers on the 1st and 2nd shift. Staff are to document when completed, refused or not completed. Review of Resident #17's report forms revealed the following: -August 21-31, 2021 one bath was documented as being completed on 8/21. -September 2021 4 baths were documented as being completed: 9/8, 9/15, 9/18, and 9/22.	F 677	1. To correct this deficiency as it relates to residents #17, 18, 19, 20, 21, 22, and 23, an audit of every residents' bathing task in PCC was completed on 12/5/2021. The bathing task initiates in PCC and populates to POC for the CNAs to document baths. Each residents' bathing task was corrected in PCC for CNAs to document bathing on the appropriate days and shifts. The residents' scheduled bath days and shift were added to the task and the resident's Kardex. This provides the CNAs with ready access to know when baths are scheduled. It also enables the CNAs to document in POC the baths they give, and enables nurse management to audit bath documentation. 2. To protect other residents in similar situations, education on resident bathing schedule protocols and documentation of bathing was provided to nursing staff beginning on 12/17/21. 3. To ensure the problem does not recur, DON or designee will complete a daily audit of the previous day's baths (see attached "Bath Spreadsheet".)	

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	165524	A. BUILDING _____ B. WING _____	C 12/01/2021

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F 677	Continued From page 12 -October 2021 7 baths were documented as being completed: 10/2, 10/9, 10/13, 10/16, 10/20, 10/27, and 10/30. -November 1-19 2021 3 baths were documented as being completed: 11/3, 11/10, and 11/17. 2.The MDS assessment dated 10/27/21 for Resident #18 identified a BIMS score of 15. A score of 15 indicated no cognitive impairment. The MDS documented she required physical help limited to transfer only of one staff member. The MDS documented diagnoses that included: atrial fibrillation, heart failure, renal failure, anxiety, depression, respiratory failure, and sleep apnea. Review of Nursing Staff 24 Hour Shift Report form 8/21/21-11/19/21 revealed the following; it listed what residents needed showers on the 1st and 2nd shift. Staff are to document when completed, refused or not completed. Review of Resident #18's report forms revealed the following: -August 21-31, 2021 two baths were documented as bed baths, being completed on 8/24 and 8/27. -September 2021 5 baths were documented as being completed: 9/3 refused because it was too late, 9/7, 9/10, 9/14, 9/17, 9/21 left blank, and 9/24 bed bath. -October 2021 0 baths were documented as being completed: no refusals, no bed baths completed. -November 1-19 2021 0 baths were documented as being completed: 11/4 left blank and 11/13 left blank. On 11/23/21 at 10:01 AM Resident #18 stated her and her roommate Resident #19 got a bath for the first time in 2 weeks recently. Both residents	F 677	4. To monitor performance and to ensure solutions are permanent, DON or designee will total baths provided to each resident weekly for 3 months. The weekly totals will be reported to the QAPI Committee for 3 months. The QAPI Committee will then determine if further reporting and/or monitoring is to continue.	

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F 677	Continued From page 13 provided they do not get their baths and it happens a lot. 3.The MDS assessment dated 9/7/21 for Resident #19 identified a BIMS score of 15. A score of 15 indicated no cognitive impairment. The MDS documented bathing did not occur during the 7 day review period. The MDS documented diagnoses that included: type 2 diabetes, heart failure, renal failure, stroke, and seizure disorder. Review of Nursing Staff 24 Hour Shift Report form 8/21/21-11/19/21 revealed the following; it listed what residents needed showers on the 1st and 2nd shift. Staff are to document when completed, refused or not completed. Review of Resident #19's report forms revealed the following: -August 21-31, 2021 two baths were documented as being completed on 8/25 and 8/27. -September 2021 2 baths were documented as being completed: 9/1 refused, 9/8, 9/15 left blank, and 9/18. -October 2021 0 baths were documented as being completed: no refusals, no bed baths completed 10/27 left blank and 10/30 left blank. -November 1-19 2021 0 baths were documented as being completed: 11/4 left blank and 11/13 left blank. 4.The MDS assessment dated 10/6/21 for Resident #20 identified a BIMS score of 13. A score of 13 indicated no cognitive impairment. The MDS documented she required supervision of one staff for bathing. The MDS documented diagnoses that included: respiratory failure, anemia, anxiety, depression, and atrial fibrillation.	F 677		

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F 677	Continued From page 14 Review of Nursing Staff 24 Hour Shift Report form 8/21/21-11/19/21 revealed the following; it listed what residents needed showers on the 1st and 2nd shift. Staff are to document when completed, refused or not completed. Review of Resident #20's report forms revealed the following: -August 21-31, 2021 0 baths were documented as being completed. -September 2021 0 baths were documented as being completed: 9/24 refused. -October 2021 2 baths were documented as being completed: 10/8 and 10/22. -November 1-19 2021 3 baths were documented as being completed: 11/2, 11/9, 11/16 and 11/19 refused. 5. The MDS assessment dated 11/9/21 for Resident #21 identified a BIMS score of 15. A score of 15 indicated no cognitive impairment. The MDS documented bathing did not occur during the 7 day review period. The MDS documented diagnoses that included: coronary artery disease, renal failure, diabetes mellitus, sleep apnea, and COVID-19. Review of Nursing Staff 24 Hour Shift Report form 8/21/21-11/19/21 revealed the following; it listed what residents needed showers on the 1st and 2nd shift. Staff are to document when completed, refused or not completed. Review of Resident #21's report forms revealed the following: -August 21-31, 2021 2 baths were documented as being completed: 8/25 and 8/27. -September 2021 2 baths were documented as	F 677		

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F 677	Continued From page 15 being completed: 9/1, 9/8 left blank, 9/11 left blank, 9/15 left blank and 9/18. -October 2021 1 bath was documented as being completed: 10/27 and 10/30 left blank. -November 1-19 2021 4 baths were documented as being completed: 11/3, 11/6, 11/10 and 11/13. On 11/12/21 at 10:22 AM Resident #21 stated she will refuse her bath when they only have 2 staff on her hall. She provided there are other residents that require more help than her and does not want to take that away from them. 6. The MDS assessment dated 11/17/21 for Resident #22 identified a BIMS score of 15. A score of 15 indicated no cognitive impairment. The MDS documented she required physical help limited to transfer only of 1 staff. The MDS documented diagnoses that included: coronary artery disease, neurogenic bladder, respiratory failure, and atrial fibrillation. Review of Nursing Staff 24 Hour Shift Report form 8/21/21-11/19/21 revealed the following; it listed what residents needed showers on the 1st and 2nd shift. Staff are to document when completed, refused or not completed. Review of Resident #22's report forms revealed the following: -August 21-31, 2021 0 baths were documented as being completed. -September 2021 0 baths were documented as being completed: 9/13 self-bed bath, 9/18 left blank. -October 2021 0 baths were documented as being completed: 10/27 left blank and 10/30 left blank. -November 1-19 2021 2 baths were documented	F 677		

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F 677	Continued From page 16 as being completed: 11/3 left blank, 11/4, 11/6, 11/10 left blank and 11/13 left blank. On 11/23/21 at 10:46 AM the resident stated she does not get her bath like she should. She indicated staff will not tell her when her bath days are so she will go in the bathroom, strip down and give herself a bed bath. When asked what is the longest she has gone without a bath she stated a couple weeks. 7. The MDS assessment dated 9/1/21 for Resident #22 identified a BIMS score of 15. A score of 15 indicated no cognitive impairment. The MDS documented he required total dependence of 1 staff for bathing. The MDS documented diagnoses that included: renal failure, diabetes mellitus, seizure disorder, depression, and COVID-19. Review of Nursing Staff 24 Hour Shift Report form 8/21/21-11/19/21 revealed the following; it listed what residents needed showers on the 1st and 2nd shift. Staff are to document when completed, refused or not completed. Review of Resident #23's report forms revealed the following: -August 21-31, 2021 1 bath was documented as being completed: 8/21. -September 2021 3 baths were documented as being completed: 9/15, 9/18, and 9/22 left blank. -October 2021 3 baths were documented as being completed: 10/2 left blank, 10/9 refused, 10/12, 10/13 blank, 10/16 blank, 10/20 blank, 10/26, 10/27 left blank, and 10/30. -November 1-19 2021 2 baths were documented as being completed: 11/3 left blank, 11/10, and 11/17.	F 677		

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F 677	Continued From page 17 On 11/9/21 at 11:01 AM Staff C CNA stated residents are to get a shower/bath 2 times a week unless they refuse. If they refuse staff are supposed to attempt to offer them 3 times. There are some residents that only want one a week. Staff C indicated evening showers are not getting done as they should. The day shift will pick up showers if they haven't been done from the day before. On 11/9/21 at 12:27 AM Staff L CMA (Certified Medication Aide) stated residents are not getting their baths because staff are more concerned about getting residents up then getting them baths. She stated this is a staffing issue. On 12/1/21 at 7:41 AM the Director of Nursing (DON) stated resident baths are to be completed based on the resident's desire and care plan. She added they are offered 2 baths a week but some residents do not wish to have them twice a week. When asked if she felt they were getting completed she stated yes. When resident and concerns were brought to her attention she provided there is a CNA that works doubles several times a week. She indicated this CNA does not always complete her documentation when the baths are completed. She believes it is a documentation issue but understands if it was not documented it was not completed. The DON added if the baths were not getting done, she would know. She was informed of residents stating they have gone 2 weeks without a bath or doing their own bed baths in their baths rooms, she stated she will get to the bottom of this. When asked if the resident is listed to receive a bath on the Nursing Staff 24 Report Shift form and the area is left blank what does that mean,	F 677		

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F 677	Continued From page 18 she provided she could not speak to why staff would do that. She added those sheets are probably going to go away and start utilizing electronic charting. If the resident refuses a bath, staff are encouraged to get another staff member to ask the resident and if they still decline the charge nurse is to be notified. If staff are unable to complete their baths on the their shift, they are to pass it on to the next shift to complete.	F 677		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, family and staff interviews, facility investigative file review, and facility policy review, the facility failed to provide adequate nursing supervision and assistance devices to prevent hazards for 2 of 9 residents reviewed. (Resident #2 and #25). On 5/24/21 Resident #2 admitted to the facility from an Assisted Living because she had eloped (when a resident leaves the facility without staff knowledge or permission) twice and the facility was unable to keep her safe. In addition, the family reported the resident had eloped from their home prior to her stay at the Assisted Living Facility and indicated they informed the nursing facility of her past history of eloping from their home and from Assisted Living. The facility failed	F 689		

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F 689	Continued From page 19 to accurately complete a wandering risk assessment for Resident #2 upon her admission, and staff reported the resident ambulated (walked) around the hallways for exercise on a routine basis. On Sunday, 10/17/2021 at approximately 1:30 PM, the facility learned the resident left the nursing home and went into the basement of the facility's Assisted Living located across the parking lot when they received a phone call from Assisted Living staff. The facility reported on Saturdays and Sundays the main entrance doors were left unlocked and unsupervised so family members could enter the building to visit. These findings constituted an Immediate Jeopardy to resident health and safety. The facility also failed to assist Resident #25 from the living room of the unit to his room by pushing him in his wheelchair without his wheelchair pedals present. The facility reported a census of 89 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 6/3/21 for Resident #2 identified a Brief Interview of Mental Status (BIMS) score of 9. A score of 9 indicated moderate cognitive impairment. The MDS revealed she did not exhibit wandering behavior during the 7 day review period. The MDS documented she required supervision for bed mobility, locomotion on and off the unit, dressing toilet use, and personal hygiene. The MDS documented diagnoses that included: atrial fibrillation, coronary artery disease, dementia, and restless leg syndrome. The baseline Care Plan completed on 5/26/21 provided the resident's daughter was the resident	F 689		

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F 689	Continued From page 20 representative. The baseline Care Plan documented she required assistance of 1 staff for transfers and utilized a walker. The baseline Care Plan asked if the resident was an elopement/wander risk with the option to check yes or no; neither answers were checked. The Wandering Risk Assessment completed on 5/24/21 indicated she was at low risk for wandering. Under the history of wandering section it was not checked when ask if the resident was a known wanderer/history of wandering. The Progress Noted dated 10/17/21 at 1:46 PM documented at 1:30 PM the resident noted to have left the nursing home and went into the Assisted Living basement. Staff called the nursing home regarding the resident being in their building. Staff went to Assisted Living facility and escorted resident back to the nursing facility. Nurse assessed the resident; no signs or symptoms of injury, denied pain and discomfort. Observation on 10/28/21 at 10:30 AM revealed the main entrance doors to be unlocked, no alarms sounded when surveyor entered the facility. After entering the facility through the main entrance doors there is a dining room located directly to the right of the enter way. Observation on 10/28/21 at 3:30 PM revealed once outside of the main entrance, the sidewalk leads to a busy side street that leads to a cement water channel then a busy highway. Review of the facility's investigative file revealed the following handwritten statements: -Staff C Certified Nursing Assistant (CNA) documented she had picked up lunch room trays	F 689	3. To ensure the problem does not recur, DON or designee will complete the Wheelchair Pedal Audit form weekly for three months. DON or designee will complete progress note audits weekly for 3 months for residents admitted with a BIMS score of 12 or less. 4. To monitor performance and to ensure solutions are permanent, DON or designee will be report weekly audit findings to the QAPI Committee for 3 months. The QAPI Committee will then determine if further reporting and/or monitoring is to continue.	

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F 689	Continued From page 21	F 689		

and saw Resident #2 walking up to her about 12:45 PM. Staff C asked her if she had a mask with her, then helped her look for one and placed it on her face. The resident then proceeded to go on her normal walk down the hall. Staff C continued walking the opposite direction to finish collecting lunch room trays. It was 1:15 PM when the nurse came into another resident's room where Staff C was, to inform her the resident was found at the Assisted Living building. Staff C walked up and brought the resident back. The written statement was signed by Staff C and dated 10/17/2021.

-Staff E Licensed Practical Nurse (LPN) documented at 12:45 PM she noted the resident walking towards the nurse's station with her walker. Staff E was passing the noon medications and that was the last time she saw the resident. The written statement was signed by Staff E and dated 10/17/21.

-Staff F Restorative Aide/Certified Medication Aide (RA/CMA) documented she went to the dining room about 12:00 PM-12:30 PM. Resident #2 was in her room sitting on her bed the last time she saw her. The written statement was signed by Staff F and dated 10/17/21.

-Staff D Assisted Living Aide documented Resident #2 set off the door alarm at the AL building basement. She went downstairs to check on the alarm and found the resident wandering around. Staff D asked if she was lost and she stated she was look for Bob. Staff D asked what her name was and she did not answer. Staff asked where she came from and she pointed at the basement door. Staff D then took her upstairs to the living room to ask staff if they knew who she was. Staff again asked what her name was and she told them. Staff D then called the nursing home, described the woman and staff stated she

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F 689	Continued From page 22 lived at the nursing home. They sent someone up to get her. The written statement was signed by Staff D and dated 10/17/21. On 10/28/21 at 12:43 PM the Administrative Assistant and Medical Records/Secretary staff members provided they both work at the front deck, which is across from the main entrance. When asked who covers their breaks they stated they take turns going to break so one person is always there but if they both have to leave their desks they ask another staff member to cover. They provided the front doors are locked from 4:30 PM-8:00 AM, Monday through Friday. They stated during the weekend the doors are locked, staff enter through the loading dock and visitors enter through the locked side door. When the doors are unlocked and someone walks too close with the wander guard they stated the door will alarm and the same when the door is locked. The staff members were asked if the doors were locked when Resident #2 walked out of the main entrance, they stated they were unlocked. When asked why they stated so visitors could come in; they were left unlocked from 8:00 AM to 8:00 PM. The Administrative Assistant stated the main entrance doors are now locked completely on the weekends. On 10/28/21 at 1:09 PM Staff E stated Resident #2 would get up for breakfast, go for a walk for exercise. When asked where she walks to, she stated she will walk down the hallway to the nurse's station then back to her room. She will nap until lunch then at times she will do the same walking routine after lunch. If she did not walk in the mornings it was because she was doing activities but would walk after lunch. Staff E stated the last time she saw the resident the day	F 689		

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F 689	Continued From page 23	F 689		

she eloped was about 12:45 PM when she was passing medications; she walked passed her to the nurse's station and turned left. She wore pants, a fuzzy coat and closed toed shoes. The weather was not very chilly and it was not raining; that's all she could remember. Staff E indicated she completed the assessment when the resident was brought back to the facility; her assessment was within normal limits and she did have her walker with her. Staff E indicated the resident had never expressed wanting to leave the facility.

On 10/28/21 at 1:44 PM Resident #2's family member stated the resident did have elopement incidents while in Assisted Living. The family member reported they did not have the staff to take care of elopements. When asked if the family was asked about these elopements when the resident was admitted to the facility, the family member indicated they let the facility know of the resident trying to leave the home and had some successes. The family member also stated the facility was aware of the resident's elopements from Assisted Living. When asked which staff member(s) they spoke to about the resident's elopement history they stated the Social Worker/Compliance Officer and Staff G. The family provided Resident #2 now has a wander guard on.

On 10/28/21 at 1:48 PM the Director of Nursing (DON) was asked what measures the facility took after Resident #2 eloped from the facility and she stated they immediately put a wander guard on her. They had talked about moving her to the memory care unit but wanted to watch her for more eloping attempts. She stated the resident did start to go back to the doors so they moved her to the memory care unit. She provided they

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	165524	A. BUILDING _____ B. WING _____	C 12/01/2021

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 689	Continued From page 24	F 689		

changed some processes such as locking the main entrance doors after the desk staff leave at 4:30 PM, Monday through Friday. The main entrance doors will be locked from 4:30 PM on Friday until 8:00 AM on Monday. They educated all staff on the door lock changes.

On 10/28/21 at 2:25 PM the Social Worker/Compliance Officer provided Resident #2 was admitted from an Assisted Living facility and she had met with the daughters prior to the admission to complete paperwork. When asked what paperwork was completed prior to the resident being admitted she provided an admission packet. Review of the packet revealed no questions related to wandering or eloping. She felt the resident did very well transitioning from an apartment to the nursing home. She stated the daughters did not mention the resident had a history of eloping from their home and from Assisted Living. When asked what the reason for the resident's admission, she stated the resident was needing more assistance.

On 10/28/21 at 6:13 PM Staff F reported Resident #2 likes to walk the halls with her walker for exercise; this was typical for her. Staff F indicated she liked to do things on her own and was independent to walk around. Staff F stated the day she eloped she did not seem any different any normal. She provided the resident wore pants, fuzzy jacket and was not sure what footwear she had on when she left the facility. When asked how the resident got out of the facility, she stated the front doors were unlocked and no one sat up there during the weekend. Staff F was asked why the main entrance was left unlocked on the weekends, she provided this allowed family to come in to visit the residents.

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F 689	Continued From page 25 On 10/28/21 at 6:27 PM Staff D stated shortly after lunch she was taking her tenants back to their rooms, when the basement of the Assisted Living facility, alarm started to go off. She went downstairs to shut off the alarm when she noticed someone was walking down there; unsure who it was. The woman was walking around, looked lost with a walker and knew it was not one of their tenants. She stated the resident was wearing a fuzzy jacket, pants and shoes. When asked how one would get from then nursing home to the Assisted Living facility, she stated they would have to walk up a ramp to the back of the building. She provided a nursing home staff members came up and took the resident back to the facility. On 10/29/21 at 11:55 AM the State Climatologist reported on 10/17/21 at approximately 12:45 PM the outside temperature was 72 degrees, humidity was at 23%, winds were at 9 mile per hour (mph), no heat index, no windchill or precipitation. On 10/29/21 at 12:16 PM Staff H LPN stated when she completes the wandering questions on the assessments she will ask the family for help, if the resident has dementia, and look at the discharging entity's paperwork. When asked if Resident #2's family was involved with completing her wandering assessment she stated she does not remember but if it was during COVID, the family could be present during the assessment. If the family was not there she would have gone through paperwork and there was no indication that she was a wanderer and the family did not indicate she had a history.	F 689		

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F 689	Continued From page 26 On 10/29/21 at 3:22 PM Staff G stated Resident #2 would walk to the dining room and back. When asked to talk about the day she eloped from the facility, she provided it was reported to her that the resident was missing. She reported the incident to the DON and placed a wanderguard on the resident when she returned to the facility. She then educated staff to keep an eye on her and obtained an order to place her on the memory care unit if she continued to exit seek. Staff G was asked what education was provided to the staff immediately, she stated about the resident's wanderguard placement, to keep an eye on her more frequently than 2 hours and for the nurse to complete a new wandering risk assessment. Staff G stated she sat at the front office right across from the main entrance and then locked the doors when she left. The visitors were then updated to go to the side door right off of the parking lot, for weekend visits. On 11/3/21 at 1:39 PM the Administrator when asked whose decision it was to unlock the main entrance doors on the weekends he stated it was a discussion between himself and the leadership team. That team consisted of the previous DON and Assistant Director of Nursing (ADON). He verified that since Resident #2 eloped from the facility the facility now locks the front doors on the weekends starting at 4:30 PM on Friday until 8:00 AM on Monday. The Administrator provided visitors are now asked to enter from a side door that is locked at all times and requires a code to be entered before the doors unlock. He shared that this information was communicated to family members via email and/or a phone call. He added staff were also educated on the changes as well. When asked how the front desk is covered during breaks, he provided the two staff	F 689		

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F 689	Continued From page 27	F 689		

members do not take their breaks at the same time; this allows one person to be present at all times. When asked what if there is a call light he stated they would have another staff member sit in such as an activity personnel or the Chaplain.

On 11/9/21 at 11:01 AM Staff C stated she was passing out lunch trays the day Resident #2 eloped from the facility. She was on the hall passing out trays when the resident walked by her, which was her normal. She stopped her, asked where her mask was and assisted with putting one on and the resident continued to walk. She stated this was about 12:45 PM. Staff C continued with her tasks when a nurse came to tell her the resident have been found at the Assisted Living building. This was about 1:15 PM-1:30 PM. She went up to get her and walked her back with her walker. She stated she was surprised the resident did not have a wanderguard on because she likes to walk a lot and was not sure what she would do with the front doors being unlocked. She stated recently they unlocked the doors on the weekends so visitors could come in a visit. When asked how the resident was when she escorted her back to the facility, she stated she was happy as a clam. Once she was back Staff G put a wanderguard on the resident, she was not sure if they locked the front doors after that.

The facility was notified of the Immediate Jeopardy (IJ) on 10/29/2021. The IJ was removed on 10/29/2021 when the facility took the following actions:

a. The facility locked the main entrance doors immediately and also on the weekends when they did not have staff to supervise the entrance.

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F 689	Continued From page 28 b. Staff applied a wanderguard to Resident #2's person. c. Facility management educated all staff members with regard to the main entrance doors detailed in a., above. d. Facility management educated all staff members about where visitors would be entering the facility when the main doors were locked. These actions lowered the deficiency from a scope and severity of J to D, with the need for ongoing monitoring of hazards to maintain residents' safety. 2. The MDS assessment dated 9/9/2021 for Resident #25 identified a BIMS score of 2. A score of 2 indicated severe cognitive impairment. The MDS revealed the resident required limited assistance of two staff for transfers and extensive assistance of two staff for bed mobility. The MDS indicated he used a walker and wheelchair for mobility assistance. The MDS documented diagnoses that included: non-traumatic brain dysfunction, Alzheimer's disease, diabetes mellitus, anxiety, depression, and COVID-19. The Care Plan focus area dated 4/29/2020 indicated the resident had an Activities of Daily Living (ADL) self-care deficit related to impaired mobility, pain, Alzheimer's disease. He needs assistance with his ADLs. The Care Plan interventions included: he required two person extensive assistance for transfers and staff are always to use the walker for transfer assist. Observation on 10/28/21 at 12:58 PM revealed Staff I Certified Medication Assistant (CMA) assisted the resident to his room while in his	F 689		

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F 689	Continued From page 29	F 689		

wheelchair. Staff I failed to put on his foot pedals before pushing on his wheelchair approximately 26 feet from the day room to his room. The resident had gripper socks on at that time and could be heard sliding on the floor as he was pushed him from the day room to his room.

On 11/9/21 at 11:20 Staff J Certified Medication Aide (CMA)/Staffing Coordinator stated when staff assisted residents in their wheelchair they are to use the foot pedals.

On 11/9/21 at 11:32 PM Staff K Agency CNA stated staff are to use foot pedals when residents are being transported in their wheelchairs.

On 11/9/21 at 12:08 PM Staff M LPN provided staff should have the foot pedals on a resident's wheelchair when transporting them in it.

On 12/1/21 at 7:41 AM the DON stated foot pedals on a resident's wheelchair are to be used when actively transporting a resident in their wheelchair. When informed of staff not utilizing Resident #25's foot pedals to assist him to his room via wheelchair, she stated that is not good.

The facility policy titled Assisted Wheelchair Propelling revised 1/23/2020 indicated any resident being assisted by staff to propel their wheelchair will have the leg rests attached on their wheelchair and the resident's feet placed on the foot pedals.