STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165524	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Lutheran Home	Seven Elliott Street Council Bluffs, IA 51503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and policy review the facility failed to protect a resident from possible accidents and injuries for 1of 2 residents (Resident #38). The facility failed to provide adequate supervision to prevent elopement. On 7/20/25 between 4:30-4:40 PM the staff last saw Resident #38 standing by the front door where visitors were exiting. The door alarm sounded with Staff A responding to the alarm but he failed to locate Resident #38 and went back to his previous duties being unaware Resident #38 was outside. On 7/20/25 at approximately 5:00 PM Staff B looked out the dining room window and observed Resident #38 walking down the sidewalk past the facility, near the bridge over a creek, towards a high traffic 3 lane street with a speed limit of 35 miles per hour. The upcoming 3 lane street did not have a side walk on the side Resident #38 was walking towards. The State Agency informed the facility on 10/1/25 at 12:10 PM of the Immediate Jeopardy (IJ) that began on 7/20/25. The immediacy was removed on 7/21/25 when the facility completed the following: Door Alarm Response Policy (11/2/18) training.Missing Resident Policy (12/21/18) training. Elopement Response Drill training.The facility reported a census of 90 residents. Findings include: The Minimum Data Set (MDS) for Resident #38 dated 5/19/25 identified a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated severe cognitive impairment. The MDS documented diagnoses that included: hypertension, renal insufficiency, thyroid disorder and Alzheimer's Disease. Resident #1 was independent with transfers and ambulation. The document disclosed the resident exhibited wandering behavior 1-3 days during the assessment period and wore a wander/elopement alarm.The Care Plan dated 9/15/25 identified a wandering focus area dated 5/14/25 with staff interventions to ensure a pathway for following, monitoring for signs/symptoms of urinary tract infection and use of a Wander Guard (5/14/25). Additional interventions of escorting the resident to and from activities and staff to attend all activities to redirect the resident when necessary was added on 7/21/25. The document contained a focus area for impaired cognition related to Alzheimer's dated 5/27/25 with interventions of keeping a consistent routine and escorting to/from activities revised 9/10/25. The Wandering Risk assessment dated [DATE] revealed Resident #38 had a score of 10/16 indicating a high risk to wander. The areas identified on the document included the resident was ambulatory, had a history of wandering, and a medical diagnosis of dementia/cognitive impairment. The document contained comments that on the date of the entry the resident had been wandering the halls today, almost went through a set of doors that set off alarms. Resident is independent with ambulation and could be mistaken for a non-resident and make her way out of the building in certain circumstances. The Morse Fall Scale dated 5/12/25 revealed a score of 60/125 indicating a high risk for falling. The document identified the resident had fallen within the past 3 months, did not use ambulatory aids, impaired gait (uses furniture as assistance, keeps head down when walking) and overestimates or forgets own limitations. A facility investigation revealed on 7/20/25 Resident #38 was assisted to the main floor chapel (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(resident resided on the lower floor) for church with no staff members present. At 4:30 PM staff were paged to the chapel to assist residents back from church. Between 4:30 PM - 4:40 PM Staff L, Dietary Aide, observed the resident standing by the front door and exit the building with visitors. Staff L stated an alarm did sound, but thought it was due to the visitors not entering the door code. Staff L stated she saw Staff A, CNA, respond to the door alarm. Staff A stated he only saw visitors outside. At approximately 4:45 PM Staff B, Certified Nurse Assistant (CNA), and Staff M, CNA, observed the resident walking along the sidewalk next to the facility parking lot. The staff were able to direct the resident back inside. The resident was wearing tennis shoes, scrub pants and a sweatshirt. All Wander Guards and door alarms were tested on [DATE]. A Progress Note entry dated 7/20/25 at 3:29 AM revealed the resident exhibited wandering behavior by walking the hallways on the first floor. Review of the weather on 7/20/25 using the World Weather revealed the temperature was +88? with a real feel +100? with 70% humidity.Review of the facility's Door Logs 6/30/25 to 10/1/25 revealed the following: The facility kept weekly logs of door checks.The facility consistently did not check doors on Sundays with the exception of 7/20/25 when the resident eloped and the doors were checked after the elopement.The door alarms were not checked on 7/19/25 the day prior to the elopement. The door alarms were not checked on 7/31/25 and 8/1/25. Observation on 10/1/25 revealed the facility was located on a residential east/west road on a hill with a speed limit of 25 MPH with a sidewalk that ran along the street in front of the facility. Going down the sidewalk along the street, one walked in front of the facility towards a 3 lane road with a speed limit of 35 MPH. Prior to reaching the road pedestrians were required to cross a bridge over a water flow way. The 3 lane road did not have a sidewalk closest to the facility. On 10/1/25 at 8:55 AM Staff B stated on 7/20/25 at approximately 5:00 PM she was in the lower dining room helping residents get ready for supper, when she looked out the window and saw Resident #38 walking down the sidewalk closest to the street near the fire hydrant and walking towards the 3 lane road. The staff stated she had Staff M go with her out the emergency door to get the resident. The staff stated the resident was near the fire hydrant when they reached her. The staff stated the resident indicated she was hungry and going for a walk to go to dinner. The staff stated they walked the resident back up the hill and came in the main door of the facility. Staff B stated she did not recall an alarm going off for the Wander Guard system prior to the resident's elopement. The staff stated when the Wander Guard alarm goes off it would go overhead on the call light system for the entire building for the specific door and what resident has exited. On 10/1/25 at 11:15 AM Staff E, Licensed Practical Nurse (LPN), stated on 7/20/25 he was working on the lower floor where the resident resided and was notified by staff of the elopement. The staff reported the church volunteers took the resident upstairs for the service and did not return her. The staff stated he did not observe the resident outside. Staff E stated he had checked her Wander Guard monitor and it was functioning. The staff stated the doors should lock when a resident was within 3 feet of the door and staff have to enter the door code and wander guard code to exit. On 10/1/25 at 11:35 AM Staff N along with the Receptionist demonstrated how the Wander Guard system worked with the main doors using a Wander Guard monitor. When the staff approached the main door with the monitor the doors would lock and the alarm wound sound. If the door code was entered with the monitor greater than 3 feet away the door would open without an alarm. If while the door was open and the monitor came closer to the door the alarm would sound and continue to sound until it was disarmed. On 10/1/25 at 12:35 PM Staff A stated he was working on the main floor on the date of the elopement. The staff stated the door alarms had been going off frequently that day due to visitors not entering the door code prior to exiting. The staff stated the alarm that went off when the resident eloped was the door (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	alarm, not the Wander Guard alarm system. The staff stated he was not aware of a resident going out the door until much later. The staff stated when he came to the front door Staff L was attempting to shut the door alarm off. Staff A stated when the Wander Guard alarm went off a XD number code was revealed on the call light screen in the hallways indicating it was the Wander Guard. The staff stated when the alarm went off at the time of elopement the screen revealed R meaning right main door. On 10/2/25 at 8:00 AM the Administrator stated she would need the facility's policy regarding the frequency of doors to be checked. The Administrator expected staff to respond and follow the policies for door alarms and missing residents. The facility's Elopement Awareness Protocol, 7/21/22, provided door alarm checks and Wander Guard/Code alert checks were to be completed Monday through Saturday and Elopement Drills were to be completed routinely and documented. The facility's Door Alarm Response, 11/2/18, revealed staff were to immediately respond to the door that was sounding, walk outside, and scan the grounds to identify the source of the alarm. The document revealed if the source of the alarm was not identified, account for all residents and if a resident was unaccountable to initiate the missing resident policy.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, document reviews and policy review the facility failed to provide nursing staff to assure residents safety by not responding to call lights in a timely manner for 6 of 27 residents reviewed (Resident #35, #42, #10, #30, #50 and #76). The facility reported a census of 90.Findings include: 1. Resident #35's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The document listed Resident #35 as frequently incontinent of bladder and bowel. The MDS listed the resident as requiring substantial/maximal assistance for toileting hygiene, bed mobility and transfers. Resident #35's Care Plan dated 9/24/25 revealed an Activities of Daily Living (ADLs) focus area, revised 9/9/25, with interventions of assisting with cares (9/3/25), bilateral bed rails (9/3/25), and reporting further deterioration to provider (9/3/25). The document included a urinary incontinence focus area dated 9/9/25 with interventions including incontinence care following each incontinence episode (9/9/25), report signs and symptoms of urinary tract infections (UTIs), and assist to toilet (9/9/25). On 9/30/25 at 2:46 PM Resident #35 stated call lights take a long time to be answered, sometimes longer than 15 minutes. The resident stated staff will come in at times, shut the call light off, say they will return and then do not. The resident stated he has been late to activities due to staff not answering his call light. On 10/1/25 at 5:45 AM Resident #35 stated he has been late to activities due to staff not answering his call light. 2. Resident #42's MDS dated [DATE] revealed a BIMS score of 15/15 indicating normal cognition. The document listed Resident #42 as frequently incontinent of bladder and bowel. The MDS provided the resident required substantial/maximal assistance with toileting hygiene, and transfers. Resident #42's Care Plan dated 9/25/25 revealed an ADL focus area (7/24/25) that included interventions with providing assistance with care, allowing extra time to complete ADLs and reporting further deterioration to the provided (7/24/25). The document contained a focus area of at risk for skin breakdown related to incontinence and impaired mobility (revised 9/25/25) with interventions of keeping areas clean and dry as possible, minimize skin exposure to moisture (7/24/25) and skin treatments as ordered (9/25/25). On 9/29/25 at 10:38 AM Resident #42 stated it would take 45 minutes or longer to answer call lights. The resident stated the staff would answer the call light and then leave with statements of takes 2 to get you up, can't get you up as we are assisting other residents either to or from the dining room, or we have reports to do. The resident stated assistance at night was limited. Resident #42 revealed she has had incontinence episodes due to staff not answering her call light and that it makes her mad and uncomfortable. 3. Resident #50's MDS dated 926/25, revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The MDS identified a diagnosis of a stroke and dependent on staff (continued on next page)

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

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