

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Bethany Life		STREET ADDRESS, CITY, STATE, ZIP CODE 212 Lafayette Street Story City, IA 50248	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474</p> <p>Based on video observation, interviews, policy, and record review, the facility failed to supervise a resident who needed cues to slow down while eating and provide adequate staff for supervision for 1 out of 5 residents reviewed (Resident #1). Due to the lack of supervision provided to Resident #1 at meals, he was able to eat his dessert very fast. As he started to choke on the dessert, the Certified Nurse Aide (CNA), passed out the meal to the other residents and didn't hear him choking. When the nurse arrived, she alerted the CNA to the situation and took action, due to the consistency of the dessert, the staff couldn't clear the resident's airway. This resulted in his death. This failure resulted in an Immediate Jeopardy situation to the health, safety, and security of the resident. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of March 25, 2024 on April 2, 2024 at 12:14 PM.</p> <p>The Facility Staff removed the Immediate Jeopardy on March 28, 2024 through the following actions:</p> <ul style="list-style-type: none"> a. 3/25/24 all nursing home staff were educated on Geri Card expectations, purpose being to give a visual reminder of those residents that require supervision during meal time. b. House wide audit completed on 3/28/24 of all Geri-cards and Care Plans for those residents that require supervision during meal time. c. Residents that require supervision were identified, lists of those residents were placed in appropriate households. Those households were provided with education and expectations of supervision at meal time on 3/28/24. d. On 3/28/24, A notice was sent out to all of the staff and they have been reminded of the specific residents and have been trained to make sure they are supervising those that require supervision. e. Staff members that are supervising residents during dining time will be in proximity of all residents needing supervision with no other job duties at that time plan to have supervisors audit every meal for 7 days and make sure the supervision is getting done correctly. f. Starting 4/5/24, We plan to have supervisors audit a random meal every day for 3 months. This will be reported on and reviewed at Quality Assurance Performance Improvement (QAPI). <p>(continued on next page)</p>

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The scope lowered from a K to E at the time of the survey after ensuring the facility implemented education and their policy and procedures.</p> <p>The facility reported a census of 128 residents.</p> <p>Findings Include:</p> <p>Resident #1's Minimum Data Set (MDS) assessment dated [DATE] listed an admitted [DATE].</p> <p>Resident #1's Clinical Record included diagnoses of dysphagia (difficulty swallowing), dementia and history of stroke.</p> <p>Review of untitled and undated facility provided document revealed Resident #1 had a hypoxic episode that caused death, related to an occluded airway.</p> <p>Review of facility document titled Investigation Summary signed and dated 3/25/24 revealed Resident #1 was coughing at mealtime after consumption of brownie and coughed a few times and then showed signs of hypoxia. Heimlich was attempted several times unsuccessfully by multiple staff. The Police department, First Responders and Emergency Medical Technicians then arrived and took over.</p> <p>Review of Resident #1's Care Plan revealed the following information:</p> <p>a. Regular diet, cut all food into bite sized pieces. Half portions of all desserts with date initiated 3/15/24.</p> <p>b. Finger foods when unable to use utensils. Staff supervision with intakes. Provide 1 food at a time. Cue to slow down at meals with a date initiated 3/15/24.</p> <p>c. Monitor, document, report as needed any signs or symptoms of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals with date initiated 3/15/24.</p> <p>Review of Resident #1's progress notes revealed the following information:</p> <p>a. 3/25/24 at 2:38 PM, Resident #1's wife left with Resident #1's personal belongings. The Funeral Home was notified and the wife declined an autopsy at this time.</p> <p>b. 3/25/24 at 2:47 PM, order received to release the body to the funeral home of choice.</p> <p>Review of Resident #1's electronic health record lacked documentation regarding information on the incident that occurred on 3/25/24.</p> <p>Review of written statements provided by the facility revealed the following:</p> <p>a. Staff E, Licensed Practical Nurse (LPN) dated 3/25/24 , almost done with lunch and went to tell Staff D, Certified Nursing Assistant (CNA), she was going to another household when she seen Resident #1 coughing. She pulled him back from the table because of dignity concerns and saw his lips turning blue.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>b. Staff D, (CNA), dated 3/25/24 around noon Staff E got my attention, Resident #1 was blue in the face. In the dining room, was helping serve plates. Didn't notice choking while eating lunch, consumed his plate and moved onto dessert. He had his caramel brownie in front of him for a few minutes before had trouble. He ate his lunch so fast but was not choking prior to this. He often needed verbal cues to slow down eating.</p> <p>c. Staff I, homemaker dated 3/25/24 the CNA helped take orders, she read all the Geri cards and Staff I dished out all the food and handed the plate to the CNA as she was helping serve.</p> <p>Interview on 3/27/24 at 3:09 PM Staff D, (CNA), revealed she was in the dining room and was monitoring the residents when Staff E, LPN, got her attention regarding Resident #1. Staff D revealed the homemakers send Resident #1's food cut up into bite sized pieces for him. Staff D revealed she could not remember if she had given any reminders to Resident #1 to slow down during the meal or not.</p> <p>Interview on 3/27/24 at 3:50 PM Staff E, LPN, revealed she had come around the corner and into the dining room and was going to tell Staff D she was going to another household to give insulin but Staff D did not hear her and she came closer into the dining area and that is when she noticed Resident #1 coughing. At that time, she had noticed Resident #1 had a mess on his clothing protector and was coughing with his mouth closed. Staff E explained she told him to spit it out and a large amount of food came out of his mouth and that is when she noted that his lips were starting to turn blue.</p> <p>Interview on 3/27/24 at 3:52 PM Staff F, Homemaker revealed she had come back over to Resident #1's household and the meal plates were already being served. She revealed that she dished up his dessert into the dish and cut up his brownie into bite sized pieces.</p> <p>Interview on 3/27/24 at 4:04 PM Staff H, Certified Medication Assistant (CMA), revealed Resident #1 needed reminders during meals to slow down while eating. Staff H further revealed that reminding Resident #1 needed to be done several times not just a one-time reminder during meals.</p> <p>Interview on 3/27/24 at 4:43 PM the Director of Nursing (DON) revealed upon admission of Resident #1 his wife had explained to the facility what she had been doing at home during meals. The DON revealed Resident #1 was very impulsive and needed supervision. The DON further revealed the facility added the supervision and verbal cues to his Care Plan to continue the care.</p> <p>Interview on 3/28/24 at 11:17 AM the DON revealed all the residents in the dementia unit are to be supervised. The DON revealed there are residents in the facility other than in the dementia unit that need supervision or assistance with eating.</p> <p>Interview on 3/28/24 at 11:21 AM the DON revealed the facility expects when residents are to be supervised for choking issues it means eyes on the resident while serving and eating of the meal is occurring.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 3/28/24 at 11:59 AM Staff E revealed the day the incident occurred she had her medication cart parked on the west wall and was unable to see into the dining room with the long table. Staff E further revealed she has since moved her medication cart to the south wall so that she is able to see into the dining room with the long table. Staff E revealed on 3/25/24 she came around the corner into the dining room to tell Staff D she was going to another household and Staff D was up at the kitchen window with her back to the residents and dining table. That is when she seen Resident #1 coughing.</p> <p>Interview on 3/28/24 at 12:06 PM Staff D revealed she was by the long table at the serving window when Staff E got her attention. Staff D revealed she served Resident #1 his brownie and it was cut up into bite sized pieces. Staff D did not recall hearing any resident cough prior to Staff E getting her attention for Resident #1. Staff D revealed she only turned her back to the residents when she was getting another plate from the kitchen to serve. Staff D further revealed supervision with meals means mostly being in the area and making sure residents are supervised.</p> <p>Interview on 3/28/24 at 12:26 PM Staff G, Registered dietician revealed she had met with the Resident #1's family prior to care conferences being held. Staff G explained Resident #1's wife had cared for him at home and explained Resident #1 needed to have supervision during meals, his food cut up into bite sized pieces, and one item at a time. Staff G stated the physician had ordered him a regular diet but the facility implemented the interventions the wife had done at home. Staff G further explained supervision for Resident #1 means eyes are to be on him and able to cue him as needed.</p> <p>Interview on 4/1/24 at 2:06 PM Resident #1's wife revealed she had talked to the facility on admission regarding the assistance he needed with meals. Resident #1's wife explained to the facility she had been cutting his food up very small, only giving him one item at a time, and being with him and watching him the entire time he would eat. She explained that Resident #1 would eat all the food that was placed in front of him until his plate was empty unless someone was watching him. She further revealed she told the facility staff several times they needed to watch him while he was eating.</p> <p>Interview on 4/1/24 at 5:04 PM Staff F revealed Staff D was at the window helping Staff F and Staff I serve the lunch meal. Staff D was turned facing into the kitchen and had her back towards the dining room and residents eating.</p> <p>Review of facility provided policy titled Meal Supervision and Assistance with an approval date of 8/23/23 revealed the following information:</p> <p>a. The resident will be prepared for a well balanced meal in a calm environment, location of his or her preference and with adequate supervision and assistance to prevent accidents, provide adequate nutrition and assure an enjoyable event. This includes identifying hazards and risk, evaluating and analyzing hazards and risks, implementing interventions to reduce hazards and risk, and monitoring for effectiveness and modifying interventions when necessary.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>b. Definitions include supervision and adequate supervision refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is determined by assessing the appropriate level and number of staff members required, the competency and training of the staff, and the frequency of supervision needed. This determination is based on the individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident.</p> <p>c. The facility will develop and implement an individualized Care Plan based on the Resident Assessment Instrument to address the resident's needs and goals and to monitor the results of the planned interventions such as adequate supervision during meal time.</p> <p>d. Do not serve the meal until the attendant is ready to assist the resident.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474</p> <p>Based on interviews, record review, and policy review, the facility failed to ensure call lights responded to in a timely manner for 4 out of 4 residents reviewed (Residents #8, #9, #10 and #11). The facility reported a census of 128 residents.</p> <p>Findings include:</p> <p>1. Interview on 4/2/24 at 2:41 PM Resident #8 revealed she has to wait a long time for the staff to take her to the bathroom, so she takes herself. Resident #8 further revealed she doesn't feel there is enough staff in the facility to take care of her needs.</p> <p>Review of the facility provided document titled Alarm Response Report dated 4/2/24 with report dates from 3/26/24 - 4/2/24 revealed the following:</p> <p>a. On 3/28/24 the call light turned on at 8:08 AM, and was on for 17 minutes.</p> <p>b. On 3/30/24 the call light turned on at 8:46 AM, and was on for 29 minutes.</p> <p>2. Interview on 4/2/24 at 2:49 PM Resident #9 revealed she does not get out of bed at times because the facility doesn't have enough staff to transfer her to her wheelchair. She continued, she doesn't get dressed on those days either. Resident #9 revealed she would like to get up and get out of her room instead of being in bed all day. Resident #9 further revealed that when she uses her call light, it takes the staff a long time to answer it.</p> <p>Review of the facility provided document titled Alarm Response Report dated 4/2/24 with report dates from 3/26/24 - 4/2/24 revealed the following:</p> <p>a. On 3/26/24 the call light turned on at 6:00 PM, and was on for 17 minutes.</p> <p>b. On 3/30/24 the call light turned on at 5:34 PM, and was on for 24 minutes.</p> <p>c. On 4/2/24 the call light turned on at 9:40 AM, and was on for 22 minutes.</p> <p>3. Review of Resident #10 progress notes revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. Resident #10's wife reported she turned the call light on, but when staff did not come she walked out into the hallway and yelled out to staff while walking up and down the hall. Resident #10's wife reports no staff was able to be found, nor emerged from the other resident's room. Resident #10's wife then ambulated out of the unit into the hall. This is where a Registered Nurse (RN), who was in another household heard a woman calling out from the hallway, [NAME] Hoo!! repeating this call. This RN went to the doorway when the door opened up from the outside. Resident #10's wife had pushed the automatic button and this RN recognized Resident #11 in her nightgown, with no footwear and no walker. Resident #11 was short of breath and reported Resident #10 had fallen and was on the ground in their room. When the RN went to Resident #10's room, she saw him alert and sitting with his back against his recliner.</p> <p>Review of the facility provided document titled Alarm Response Report dated 4/2/24 with report dates from 3/26/24 - 4/2/24 revealed the following:</p> <p>a. On 3/26/24 the call light turned on at 1:52 PM, and was on for 23 minutes</p> <p>4. Interview on 4/2/24 at 3:52 PM Resident #11 revealed it depends on who is working on quickly the call light gets answered. Resident #11 revealed Resident #10 had fallen and she couldn't find anyone in their household, she left the household to find help Review of the facility provided document titled Alarm Response Report dated 4/2/24 with report dates from 3/26/24 - 4/2/24 revealed the following:</p> <p>a. On 3/26/24 the call light was turned on at 1:52 PM, and was on for 24 minutes.</p> <p>b. On 3/26/24 the call light was turned on at 7:02 PM, and was on for 43 minutes.</p> <p>c. On 3/26/24 the call light was turned on at 9:02 PM, and was on for 23 minutes.</p> <p>d. On 3/30/24 the call light was turned on at 1:01 PM, and was on for 21 minutes.</p> <p>Review of facility provided policy titled Call Light Response with a review date of 8/21/23 revealed the purpose of this policy is to ensure that all call lights are answered promptly (Prompt response being considered as no longer than 15 minutes). The policy continues with the scope of the policy is the call light is to be answered within 15 minutes or less and the responsibility is all staff are responsible for answering a resident's call light any time that was on.</p> <p>Interview on 4/3/24 at 7:52 AM the Director of Nursing revealed the expectation is all call lights are answered in 15 minutes or less.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>44474</p> <p>Based on record review, policy review, and staff interviews the facility failed to provide accurate resident records for 1 of 4 residents (Residents #1). Following Resident #1's death, the facility failed to document the situation in his clinical record until after the start of the survey, two weeks later. The facility reported a census of 128 residents.</p> <p>Findings include:</p> <p>The clinical record for Resident #1 documented diagnoses of dysphagia (difficulty swallowing), dementia and history of stroke. The MDS showed the Brief Interview for Mental Status (BIMS) score not completed.</p> <p>Review of untitled and undated facility provided document revealed Resident #1 had a hypoxic episode that caused death, related to an occluded airway.</p> <p>Review of facility document titled Investigation Summary signed and dated 3/25/24 revealed Resident #1 was coughing at mealtime after consumption of brownie and coughed a few times and then showed signs of hypoxia. Heimlich was attempted several times unsuccessfully by multiple staff. The Police department, First Responders and Emergency Medical Technicians then arrived and took over.</p> <p>Review of Resident #1's progress notes revealed the following information:</p> <p>a. 3/25/24 at 2:38 PM, Resident #1's wife left with Resident #1's personal belongings. The Funeral Home was notified and the wife declined an autopsy at this time.</p> <p>b. 3/25/24 at 2:47 PM, order received to release the body to the funeral home of choice.</p> <p>Review of Resident #1's electronic health record lacked documentation regarding information on the incident that occurred on 3/25/24.</p> <p>Review of facility provided policy titled Documentation in Medical Record with a review date of 12/12/23 revealed each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.</p> <p>Review of facility provided policy titled Medical Records with approval date of 8/8/23 revealed the facility will maintain clinical records on each resident in accordance with accepted professional standards of practices that are complete, accurately documented, readily accessible, and systematically organized.</p> <p>Interview on 4/3/24 at 7:52 AM the Director of Nursing (DON) revealed when there is an incident, it should be charted in the resident's chart.</p>		