STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165424	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Life	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)
F 0689 Level of Harm - Actual harm 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** 35438 Based on observation, clinical record review, facility policy review, resident, and staff interviews, the facility failed to ensure one (1) of six (6) residents (Resident #6) received adequate supervision to protect against hazards in the environment. On 4/22/24, staff witnessed Resident #6 fall. As Resident #6 fell , the staff assisted her without the use of a gait belt to ambulate (walk) and transfer to the bathroom. Resident #6's fall required a transfer to the local emergency department (ED). The (ED) record revealed Resident #6 received fractures of the 1st, 2nd, 3rd, and 5th proximal phalanges (toes). The facility reported a census of 125 residents. Findings include: 1. Resident #6's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognitive skills for decision making. Resident #6 required substantial/maximal assistance for toilet transfers and total dependence from staff for walking. The MDS included diagnosis of polyosteoarthritis (arthritis that affects multiple joints at once), left artificial knee joint, and atrial fibrillation (irregular heart rate). The MDS reported no previous falls. The Care Plan Focus revised 6/12/23 indicated Resident #6 had an activities of daily living (ADL) self-care performance deficit related to weakness from her recent left knee replacement. The Care Plan interventions directed the following: a. 6/12/23: Follow facility protocol as Resident #6 allows for gait belt usage. b. 6/15/23: Transfer with an upright walker. Assist of one staff person. The Incident Report dated 4/22/24 relfected Staff A, Certified Nursing Assistant (CNA), reported to the nurse at 6:00 a.m. on 4/22/24, as she walked Resident #6 to the bathroom using her walker, she started to back into the bathroom. As she backed into the room, her walker started to tip sideways. Immediately after, Resident #6 started bending at the knee leading her to believe Resident #6 was going to fall to the floor. Staff A lowered Resident #6 to the floor as gently as could she but Resident #6 still had her knees bent and her right knee caught on the walker breaking the skin. Resident #6 expressed concern for her knees and legs. (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 - Actual harm Residents Affected - Few	The 01 Nursing Progress Note dated 4/22/24 at 6:15 a.m. indicated Resident #6 walked to the bathroom with her walker, turned to back into the bathroom, and then sat down on the floor. Resident #6 obtained an abrasion to the right knee from the walker. Resident #6's assessment indicated she could move all of her extremities. Resident #6 stated she hoped she didn't mess up her legs. The 01 Nursing Progress Note dated 4/22/24 at 9:34 a.m. reflected the facility sent Resident #6 to the local ED for evaluation due to her fall that morning. The facility notified Resident #6's family, who planned to meet her there. The 01 Nursing Progress Note dated 4/22/24 at 12:35 p.m. indicated the facility received report from the ED nurse. The nurse stated Resident #6 broke the left digits (toes) #1, 2, 3, and 5. Resident #6 would return with a special shoe. They recommended she rest and do activity as she tolerated. The Facility Investigation Summary Report signed by the Director of Nursing (DON) on 4/22/24 at 6:00 a.m. described Resident #6 as tearful and concerned the fall would set her back if she had an injury. The facility interviewed Staff A, who admitted she didn't use a gait belt to transfer Resident #6. When the staff interviewed Resident #6, she said she asked Staff A to use the gait belt but she just wouldn't do it. Resident #6 added she should never have let her help if she wasn't going to do it right. The facility terminated Staff A for not using a gait belt, due to it being a safety concern and a violation of a policy. On 5/2/24 at 11:30 a.m. observed the Assistant Director of Nursing (ADON) and Provider assess Resident #6. Witnessed Resident #6's left foot exposed, swollen, with the toes and foot darkened in color. Resident #6 stated that she had a lot of pain in the foot. The Provider discussed going to the local ED to have her foot further evaluated due to her pain, discoloration, and swelling. Noted Resident #6 tearful as she agreed. In an interview on 5/6/24 at 10:00 a.m. Resident #6 reported she had told the aide to use the gait belt, but she just wouldn't do it. Clarified that staff always use a gait belt when transferring. Resident #6 denied being afraid of falling again. In an interview on 5/2/24 at 11:05 a.m. Staff A stated that towards the end of her shift, approximately 6:00 a.m. on 4/22/24 she assisted Resident #6 to the bathroom. Staff A described Resident #6's walker as tall and when she turned to back into the bathroom the walker tried to tip sideways and Resident #6's knees bent. Staff A tried to ease her to the floor the best that she could. Staff A stated Resident #6 expressed concern about her knee and her leg immediately after her fall. Staff A responded that she didn't use a gait belt for the transfer even though she knew Resident #6 needed one with transfers. When the Surveyor questioned if she had an available gait belt, Staff A responded someone stole hers that the facility provided, so she didn't have one with her at the time. Staff A added she didn't attempt to get a new gait belt or to borrow a gait belt. Staff A stated she knew the facility required a gait belt for all staff assisted transfers. Staff A stated the facility terminated her for not using a gait belt during the transfer. She hasn't returned to work. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/2/24 the Director of Nursing (DON) explained it is a facility policy and an expectation for staff to use a gait belt for all staff assisted transfers. The DON reported the facility educated Staff A, gave her a gait belt, and signed the expectation acknowledgement. The DON stated Resident #6 reported that despite asking Staff A to use a gait belt, she didn't have one on. The DON explained the facility terminated Staff A on 4/22/24 for violation of facility policy and protocol for not using a gait belt for a staff assisted transfer. During a following interview on 5/2/24 at 12:05 p.m. the DON revealed the facility provided gait belts and educated the staff a new gait belt is available at the front desk with access through the charge nurse 24 hours, 7 days a week. Observed 10 new gait belts inside a drawer at the front desk. The Gait Belt Usage document last reviewed 8/8/23 instructed to use gait belts to safely assist residents with transfers and walking. The policy directed to use gait belts on Care Planned residents that require assistance with ambulation and or transfers unless otherwise specified. The Gait Belts facility document directed a gait belt must be with employees at all times and used for every transfer. If staff did not bring their own, the facility will provide one. Staff A signed the agreement on 4/22/24 to use a gait belt for all transfers and have one with them at all times when working and caring for residents at the facility. Additionally, Staff A agreed that not using a gait belt could result in termination. Staff A further indicated by an X that she received a gait belt by the facility. The Employee Action Form dated 4/22/24 identified the facility terminated Staff A for not following the gait belt policy.