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	10/08/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinic record review, staff interviews, Nurse Practitioner interview, and policy review, the facility failed to administer medications per physician orders for 1 of 4 residents reviewed (Resident #1) for significant medication errors. The facility reported a census of 116 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMs) score of 15, indicating intact cognition. The MDS identified Resident #1 required substantial/maximal assistance with bed mobility and was dependent on staff for transfers/toileting. The MDS included diagnoses of chronic kidney disease, generalized anxiety disorder, major depressive disorder, and primary insomnia. The MDS identified Resident #1 received antianxiety medication for 7 days during the look back period.The Care Plan revised 12/10/24 documented Resident #1 used an antianxiety medication for an anxiety disorder. The care plan directed staff to administer the antianxiety medication as ordered by the physician. The June 2025 Medication Administration Record (MAR) directed staff to administer the following antianxiety medications:- Ativan (Lorazepam) 0.5 mg (milligrams) before meals (7:30 AM, 11:30 AM and 4:30 PM) for anxiety. Start date 12/24/23- Clonazepam (Klonopin) 0.5 mg one tablet at bedtime for anxiety. Start date 2/3/23An Incident Report titled Medication Error dated 6/17/25 documented a Certified Medication Aide (CMA) went to the nurse because they suspected a medication error. The CMA identified Resident #1's clonazepam had been only signed out every other night on the narcotic record. The Nurse reviewed the most recent narcotic record for the lorazepam and identified on multiple occasions the lorazepam was given four times daily instead of the clonazepam. The report documented the nurse notified the nurse practitioner, family and on call nurse manager of the medication error. Review of the Lorazepam Narcotic Records from 6/1/25 to 6/17/25 revealed Resident #1 received an additional dose of Lorazepam in the evening/bedtime on the following dates: 6/2, 6/4, 6/5, 6/8, 6/10, 6/11, 6/13, and 6/16. Review of the Clonazepam Narcotic Records from 6/1/25 to 6/17/25 revealed Resident #1 did not receive the medication on the following dates: 6/2, 6/4, 6/5, 6/8, 6/10, 6/11, 6/14, and 6/17. A Progress Note dated 6/5/25 documented Resident #1 complained of feeling very shaky and unsteady and did not want to be left alone stating to staff she was going to die. Resident #1 reported it was her anxiety. The note indicated the Advance Registered Nurse Practitioner (ARNP) was notified of the symptoms.A Progress Note dated 6/6/25 documented Resident #1 did not feel well. When the nurse asked to describe how she was feeling, Resident #1 responded in my head, I didn't sleep much. The note documented Resident #1's daughter reported she was getting a lot of phone calls.A Social Service Progress Note dated 6/12/25 documented Resident #1 reported not doing so well because she did not sleep so well last night. A Progress Note dated 6/14/25 documented Resident #1 reported to the nurse that she wasn't feeling well and did not sleep last night.A Progress Note dated 6/14/25 documented Resident #1's daughter requested to speak to the nurse due to concern her mom was not feeling well and needed to be evaluated. The note documented Resident #1 complained of not sleeping well for the past few days, having a hard time emptying her bladder and pain all over. The note indicated Resident #1 appeared anxious, stated I feel tense and wanted to be evaluated in the hospital. The note revealed Resident #1's daughter escorted her to the hospital. A Telehealth Psychiatric Evaluation completed in the emergency room (ER) dated 6/14/25 revealed Resident #1 presented with acute insomnia and associated mood changes. The treatment recommendation was to start Trazodone (antidepressant) 25 mg at bedtime for 7 days for insomnia. A ER Provider Note dated 6/14/25 documented Resident #1 came to the ER with a chief complaint of anxiety and not sleeping. Resident #1 reported she felt tense all over and had trouble sleeping. The note revealed a medical screening was completed and Resident #1 was medically cleared. The note indicated a telehealth psychiatric evaluation was completed and recommended starting Trazodone 25 mg at bed time for 7 days. In addition the note advised the nursing home's own psychiatric provider to re-evaluate Resident #1 to determine the need to continue the medication or if the dosing needed adjusted. The note documented Resident #1 was discharged to the care center to resume her routine medications.A Progress Note dated 6/19/25 revealed Psychiatric ARNP made face to face visit with Resident #1 and no new orders were received. Review of the Lorazepam Narcotic Records dated 9/1/25 revealed the afternoon dose of lorazepam was not logged out indicating a dose was missed/omitted.On 10/7/25 at 3:00 PM, Staff A, Licensed Practical Nurse (LPN), reported she was working as a CMA when Resident #1's medication errors occurred. Staff A said she realized she had been giving Resident #1's medications incorrectly. She said