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	11/20/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident's right policy/procedure, facility investigation and staff interview the facility failed to treat a resident with respect and dignity in a manner that promotes maintenance or enhancement of his or her quality of life for 1 out of 4 residents reviewed (Resident #1). The facility identified a census of 120 residents. Findings include:Resident #1s Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 6 which indicated severe impaired cognitive decisions, usually understands and is understood by others and no behavior issues. The resident required staff dependence on toileting hygiene and frequently incontinent of bowel. The MDS included diagnoses of Cancer, hypertension, neurogenic bladder (when your brain nerves or spinal cord causes you to lose control of your bladder) and hemiplegia (a condition characterized by paralysis or severe weakness on one side of the body) of the left side.The Care Plan initiated dated 9/26/25, indicated Resident #1 has an activity of daily living (ADL) self-care performance deficit related to recent brain mass, and is resistive to cares due to cognition and grief and will refuse cares at times. Interventions included to assist times two for toileting, give clear explanation of all care activities prior to an as they occur during each contact, keep the residents routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.The facility investigation dated 10/10/25, stated that on 10/7/25, the facility administrator was notified by Staff A, Registered Nurse (RN), that she received a phone call from Staff B, Certified Nursing Assistant (CNA), who felt that Staff C, CNA, worked fast and not careful with how she handled the resident. Investigation initiated and the employee sent home. After interviewing Staff B, it was again reported that she felt that Staff C, was going fast and not taking the time that Staff B does when she works with the residents. Staff B reported that this upset her as she likes to take everything really slow and stated sometimes that makes her co-workers unhappy because she is behind. While performing peri-care, Staff B was holding Resident #1 on his side that Staff C rolled him too quickly on his side and could have been more careful. Staff B indicated that there were completing peri-care and the residents stated ow. Staff B mentioned she was not sure if Staff C heard him say that. Staff B hands remained on him when he was laid back down. Staff B stated that he may have had a small amount of bowel movement on him, she could not see as he was not facing her and was holding his body. After speaking with Staff C, she stated they went into do peri-care, his wife was still in the room and assisted with another task. Staff C reports that she did the wiping and he had bowel movement smeared between his butt cheeks. She reported she heard him say ow, I have a hemorrhoid and she did not continue to wipe in that area. She states that she told him there was some bowel movement she was trying to clean off. She did not recall if her hands were still on the resident when they rolled him back and placed a new depends. Staff C said she has performed cares for this resident many times in the past and has not had any concerns and has always gone the same pace. She states she would never purposely cause discomfort for any of our residents. After interviewing the resident, he states that he did not feel safe while the activity was being performed but stated it is her job and she did not do anything on purpose. Expectations, education and coaching provided to (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff C, to slow down, listen to the resident and ensure that things are at their pace the way they like it. Staff C verbalized understanding.Resident #1's clinical record lacked documentation of the incident.Interview on 10/27/25 at 4:45 PM, the facility Administrator verified the expectation of all staff are to treat the residents with dignity and respect at all times.The undated Resident Rights acknowledgement, described that the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility and also be free from verbal, sexual, physical and mental abuse and that the facility must ensure that all alleged violations involving mistreatment, neglect or abuse are reported immediately to the administrator of the facility.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, facility investigation, and review of policy and procedures, the facility failed to ensure all alleged violations involving mistreatment, neglect, or abuse of a resident and/or residents (Resident #1) were reported to the Department of Inspection and Appeals and Licensing (DIAL) within 2 hours. The facility reported a census of 120 residents.Resident #1's Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 6 which indicated severe impaired cognitive decisions, usually understands and is understood by others and no behavior issues. The resident required staff dependence on toileting hygiene and frequently incontinent of bowel. The MDS included diagnoses of Cancer, hypertension, neurogenic bladder (when your brain nerves or spinal cord causes you to lose control of your bladder) and hemiplegia (a condition characterized by paralysis or severe weakness on one side of the body) of the left side.The Care Plan initiated dated 9/26/25, indicated Resident #1 has an activity of daily living (ADL) self-care performance deficit related to recent brain mass, and is resistive to cares due to cognition and grief and will refuse cares at times. Interventions included to assist times two for toileting, give clear explanation of all care activities prior to an as they occur during each contact, keep the residents routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.The facility investigation dated 10/10/25, stated that on 10/7/25, the facility administrator was notified by Staff A, Registered Nurse (RN) that she received a phone call from Staff B, CNA, who felt that Staff C, CNA, was working to fast and not careful with how she handled the resident. Investigation initiated and employee sent home. After interviewing Staff B, it was again reported that she felt that Staff C, was going fast and not taking the time that Staff B does when she works with the residents. Staff B reported that this upset her as she likes to take everything really slow and stated sometimes that makes my co-workers unhappy because I am behind. While performing peri-care, Staff B, was holding Resident #1 on his side and that Staff C rolled him too quickly and could have been more careful, Staff B, indicated that there were completing peri-care and the residents stated ow. Staff B mentioned she was not sure if Staff C heard him say that. Staff B hands remained on him when he was laid back down. Staff B stated that he may have had a small amount of bowel movement on him, she could not see as he was not facing her and was holding his body. After speaking with Staff C, she stated they went into do peri-care, his wife was still in the room and assisted with another task. Staff C, reports that she did the wiping and he had bowel movement smeared between his butt cheeks. She reported she heard him say ow, I have a hemorrhoid and she did not continue to wipe in that area. She states that she told him there was some bowel movement she was trying to clean off. She did not recall if her hands were still on the resident when they rolled him back and placed a new depends. Staff C said she has performed cares for this resident many times in the past and has not had any concerns and has always gone the same pace. She states she would never purposely cause discomfort for any of our residents. After interviewing the resident, he states that he did not feel safe while the activity was being performed but stated it is her job and she did not do anything on purpose. Interviewed Resident #1's wife and she indicated that yes, he has a hemorrhoid and that is likely what caused the pain/discomfort. She also noted that he had some dry bowel movement on his sheet. I explained the aide was trying to remove the bowel movement from his buttocks, it could have appeared harsh as she had to rub to get some of the stool off.Resident #1's clinical record lacked documentation of the incident.Interview on 10/27//25 at 4:45 p.m., the facility Administrator confirmed the facility failed to notify DIAL of the incident between Resident #1 and Staff C within the 2-hour time frame. The Policy for Abuse, Neglect and Exploitation dated September 2025, the facility will have written procedures that include, reporting of all alleged violations to the Administrator or designee, state agency, within specified timeframes: Immediately, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility investigation, policy/procedures, and staff interviews the facility failed to provide a supportive and safe environment for Resident #1. On 10/8/25, the facility staff learned of a Certified Nurse Aide (CNA) being accused of slamming and making Resident #1 not feeling safe in the facility. After learning of this allegation of abuse, the facility staff told the CNA not to help Resident #1 but allowed them to work with other residents. The facility identified a census of 120 residents.Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 6 which indicated severe impaired cognitive decisions, usually understands and is understood by others and no behavior issues. The resident required staff dependence on toileting hygiene and frequently incontinent of bowel. The MDS included diagnoses of Cancer, hypertension, neurogenic bladder (when your brain nerves or spinal cord causes you to lose control of your bladder) and hemiplegia (a condition characterized by paralysis or severe weakness on one side of the body) of the left side.The Care Plan initiated dated 9/26/25, indicated Resident #1 has an activity of daily living (ADL) self-care performance deficit related to recent brain mass, and is resistive to cares due to cognition and grief and will refuse cares at times. Interventions included to assist times two for toileting, give clear explanation of all care activities prior to an as they occur during each contact, keep the residents routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.The facility investigation dated 10/10/25, stated that on 10/7/25, the facility administrator was notified by Staff A, Registered Nurse (RN) that she received a phone call from Staff B, CNA, who felt that Staff C, CNA, was working to fast and not careful with how she handled the resident. Investigation initiated and employee sent home. After interviewing Staff B, it was again reported that she felt that Staff C, was going fast and not taking the time that Staff B does when she works with the residents. Staff B reported that this upset her as she likes to take everything really slow and stated sometimes that makes my co-workers unhappy because I am behind. While performing peri-care, Staff B, was holding Resident #1 on his side and that Staff C rolled him too quickly and could have been more careful, Staff B, indicated that there were completing peri-care and the residents stated ow. Staff B mentioned she was not sure if Staff C heard him say that. Staff B hands remained on him when he was laid back down. Staff B stated that he may have had a small amount of bowel movement on him, she could not see as he was not facing her and was holding his body. After speaking with Staff C, she stated they went into do peri-care, his wife was still in the room and assisted with another task. Staff C, reports that she did the wiping and he had bowel movement smeared between his butt cheeks. She reported she heard him say ow, I have a hemorrhoid and she did not continue to wipe in that area. She states that she told him there was some bowel movement she was trying to clean off. She did not recall if her hands were still on the resident when they rolled him back and placed a new depends. Staff C said she has performed cares for this resident many times in the past and has not had any concerns and has always gone the same pace. She states she would never purposely cause discomfort for any of our residents. After interviewing the resident, he states that he did not feel safe while the activity was being performed but stated it is her job and she did not do anything on purpose. Interviewed Resident #1's wife and she indicated that yes, he has a hemorrhoid and that is likely what caused the pain/discomfort. She also noted that he had some dry bowel movement on his sheet. I explained the aide was trying to remove the bowel movement from his buttocks, it could have appeared harsh as she had to rub to get some of the stool off.Interview on 10/27/25 at 3:00 PM, Staff A, RN, verified that she received a telephone call from Staff B, CNA, claiming that Staff C, CNA, was rough and slammed Resident #1 while doing peri-care. Staff A, spoke with Staff D, Licensed Practical Nurse (LPN), and told Staff D to keep Staff C away from Resident #1. Staff A indicated that it never crossed her mind that this was an allegation of abuse and that Staff C needed to be sent home. Staff A thought that keeping Staff C away from (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 would take care of the incident.Interview on 10/27/25 at 3:35 PM, Staff C, CNA, stated that peri-cares were being completed on Resident #1 and dried stool was in-between the buttocks. Staff C stated that she was using a wet wipe to cleanse the area. Resident #1 stated ow, that hurts. Staff C, stopped doing cares and proceeded to take a clean brief and place underneath the resident with assistance of Staff B. Staff C, indicated that this incident happened between 5:00 PM - 5:30 PM. Staff C stated that she answered call lights with other residents until 6:45 PM, when she was instructed to leave the facility. Staff C stated Resident #1 had hemorrhoids and they were bleeding.Interview on 10/27/25 at 4:00 PM, Staff D, LPN, explained that Staff B came up to her and explained that Staff C was rough and slamming Resident #1 in bed while performing peri-cares. Staff D, told Staff B to call the on-call nurse to get direction on how to proceed. Staff D, stated that she got a phone call from Staff A, with direction to keep Staff C from doing cares with Resident #1. Staff D, stated that this was her first allegation of abuse and was not sure how to proceed. Staff D, spoke with Resident #1 after the incident and Resident #1 said that he did not feel safe after the incident. Interview on 10/27/25 at 4:15 PM, Staff B stated that peri-cares were being performed with Staff C and herself on Resident #1. Staff B stated that Staff C was rough and slammed Resident #1 around while performing cares and made Staff B uncomfortable. Staff B explained the incident to Staff D and Staff D told Staff B to call the on-call nurse manager. Staff B was not able to determine the time frame for the incident but stated that it was during the supper time meal. Interview on 10/27/25 at 4:45 PM, the facility Administrator verified Staff C needed sent home until an investigation was completed and that the expectation is not to take care of any other residents.The Abuse, Neglect and Exploitation Policy revised September 2025, that the facility will provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property and will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.