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	02/13/2026

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 - 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 the Resident's Rights policy/procedure, facility incident report, resident, and staff interview the facility failed to treat a resident with respect and dignity in a manner that promoted maintenance or enhancement of his or her quality of life for 1 out of 3 residents reviewed (Resident #1). On 1/18/26 at 2:00 AM, Resident #1 requested not to be checked and changed when Staff A, Certified Nursing Assistant (CNA), came into their room. Staff A, did not grant this request and proceeded to check Resident #1 against their wishes. Staff A put their hand in between Resident #1's thighs to check to see if they soiled their brief. Following the situation, Resident #1 became fearful of Staff A, and caused Resident #1 to have trouble sleeping during the night. The facility corrected the concern on 1/30/26 prior to the start of the survey by completing the following:1/29/26: Suspended the staff involved in the situation.1/30/26: Interviewed Residents affected or likely to be affected.1/30/26: Audited employee files for compliance with Dependent Adult Abuse training.1/30/26: Educated the staff related to Resident Rights and Abuse online.1/30/26: Conducted an emergency in-service.1/30/26: Completed abuse education with the nurses.1/30/26: Conducted Abuse and Resident Rights education with the leaders.1/30/26: Offered counseling to Resident #1 affected by the situation.The facility identified a census of 105 residents. Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 14, indicating no impaired cognitive decisions. Resident #1 could understand others and others understood them. They had adequate hearing, vision, and no behavior issues. Resident #1 required total staff assistance with toileting and hygiene. The MDS listed Resident #1 as frequently incontinent of bowel. The MDS included diagnoses of hypertension (a condition where blood consistently pushes hard against artery walls), heart failure, anemia, and restless leg syndrome (a neurological disorder by the urge to move the legs, and uncomfortable crawling, tingling, or aching sensations).The Care Plan Focus initiated dated 10/3/25, indicated Resident #1 had an activity of daily living (ADL) self-care performance deficit related to impaired balance. The Interventions instructed the following:a. Follow facility protocol as Resident #1 allowed for incontinence care managementb. Staff assist of one person with toiletingc. Independent with toileting hygiened. Ask yes/no questions in order to determine the resident's needs. The Care Plan Focus dated 10/20/25 reflected Resident #1 had bladder incontinence and needed assistance. The Intervention initiated 1/12/26 directed Resident #1 preferred to be changed between 1:00 AM and 3:00 AM. The Unusual Event dated 1/20/26 at 2:00 AM, documented Resident #1 reported she didn't know the date and time of occurrence, but said while in her chair, which she considered her bed, Staff A, performed cares on her roommate. Afterwards, Staff A, woke up Resident #1 to let her know it was time for check and change. Resident #1 told Staff A; she didn't want bothered. Staff A, proceeded to check her anyways by putting Staff A's hand on the outside of Resident #1's brief to determine if she was wet. Staff A, left without changing Resident #1. Resident #1 stated she was dry. (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 - Actual harm Residents Affected - Few	During the next rounds, Resident #1 told Staff A, she did not want to be bothered again, after this happened Staff A, stepped away and got the nurse. Resident #1 stated she would prefer to be woke up and checked. The Social Service Progress notes dated 2/2/26 at 3:39 PM, documented Resident #1 received a supportive visit that day.The Social Service Progress notes dated 2/3/26 at 11:24 AM, documented a referral made to psychotherapy/psychiatry services, both Resident #1 and her daughter aware and agreed to have services provided.The Social Service Progress Note dated 2/6/26 at 2:36 PM, documented the Social Worker met with Resident #1 every day that week for supportive visits.An untitled piece of paper with a date 2/2/26, documented one-on-one with Resident #1 that day. Resident #1 presented in good spirits; she mentioned some trouble sleeping related to an incident with staff. The person provided reassurance.An untitled piece of paper with a date 2/3/26, documented the Social Worker stopped in to see Resident #1 that day, they talked about how things were going. The Social Worker reassured Resident #1 again that the staff person from the recent incident is no longer at the facility.On 2/11/26 at 3:45 PM, Resident #1 stated that during the overnight shift on 1/18/26, about 2:00 AM, Staff A woke her up to check and change her. Resident #1 explained to Staff A, she was dry and don't bother her. Staff A put their hand in between Resident #1's thighs to check the outside of her brief. Resident #1 told Staff A, don't do that again. Since that incident Resident #1 is fearful of Staff A not respecting and granting her request refusing to be checked and changed. She added she had trouble sleeping related to this incident.On 2/11/26 at 1:30 PM, Staff B, Registered Nurse (RN), stated on 1/29/26, when they interviewed Resident #1, she told her on 1/18/26 about 2:00 AM, Staff A, came into her room, to check and change her. Resident #1 told Staff A, that she was dry and not to bother her. Staff A proceeded to check the outside of Resident #1's brief anyway, by putting their hands in between her thighs, even after Resident #1 told Staff A, not to. Staff B, stated they expected the staff to respect the resident's rights and dignity.On 2/11/26 at 3:00 PM, Staff A confirmed the incident happened according to Resident #1. Staff A, explained that sometime around 2:00 AM or later, Staff A woke Resident #1 up and explained it was time to be checked and changed. Resident #1 said that she was dry and not to bother her. Staff A, said they proceeded to check Resident #1 anyway, by taking their hand and putting in between her thighs to check the brief. Staff A acknowledged the facility expected the staff to treat residents with dignity and respect at all times.On 2/11/26 at 3:30 PM, the facility Director of Nursing, (DON) heard about the incident on 1/28/29, and started to investigate. During the investigation the DON found out the incident happened on 1/18/26 on the overnight shift. The DON acknowledged residents are to be treated with dignity and respect at all times. On 2/11/26 at 4:00 PM, Staff C, CNA, explained Resident #1 said an incident happened on 1/18/26 on the overnight shift about 2:00 AM. Staff A, placed their hands in between Resident #1 thighs to check to see if she was soiled after Resident #1 told Staff A that they were dry. The gesture made Resident #1 uncomfortable. Staff C, acknowledged all residents are to be treated with dignity and respect at all times.On 2/12/26 at 9:30 AM, Staff D, Occupational Therapy Assistant, explained on 1/20/26 in the morning, while ambulating Resident #1 to the bathroom, Resident #1 wanted to talk with a nurse. Staff D, proceeded to get the charge nurse. Resident #1 explained Staff A, came into her room a couple of nights before. Staff A put their hands in between Resident #1 thighs to check to see if the brief was soiled even after Resident #1 told Staff A, no she was dry. Resident #1 felt uncomfortable with this. On 2/12/26 at 1:30 PM, Staff E, Social Services, explained she didn't know about the incident with Resident #1 and Staff A, until 1/28/26. Staff E explained she went into Resident #1's room daily to do visits and made a referral to psychotherapy/psychiatry services to assist Resident #1 to work through the incident that happened. Staff E, acknowledged during one-to-one visits, (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Resident #1 stated she had trouble sleeping due to the incident. On 2/12/26 at 5:30 PM, the Administrator verified they expected all staff to treat residents with dignity and respect at all times.The undated Resident Rights acknowledgement, described the facility must care for its residents in a manner and in an environment that promoted maintenance or enhancement of each resident's quality of life. The facility must promote care for residents in a manner that enhances each resident's dignity and respect in full recognition of his or her individuality.