

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 03/04/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49698</p> <p>Based on observation, clinical record review, staff interviews, and policy review, the facility failed to treat residents with dignity and respect for 1 or 26 residents sampled (Resident #91). The facility reported a census of 117 residents.</p> <p>Findings include:</p> <p>1. Observation on 2/28/24 at 4:40 PM revealed loud talking and a commotion outside of Resident #91's unit. Upon entering the unit, Resident #91 sat in a chair in the unit's community room. Staff H, Certified Medication Aide (CMA) stood near the resident and spoke loudly and in a stern frustrated tone demanding the resident go to the table to eat, your sister is not coming, she has already left and had to work. Resident #91's face appeared red, flushed, and tearful. As two state facility surveyors entered the unit, Staff H changed her tone of voice and asked the resident to go to the dining table so he could have dinner. Resident #91 followed Staff H to the dining table. Staff H pulled the chair out from the table. Resident #91 requested the chair be moved to a different spot at the table. Staff H moved the chair and the resident sat down by the dining table.</p> <p>At 4:55 PM, Staff H stood over the resident again while he sat at the dining room table, and talked in a loud stern voice and stated You want pop don't you? Your sister has to work to buy you pop. Again the resident appeared flushed and upset. Staff H then saw the surveyors in the area and walked away from the resident.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #91 had a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. The resident had diagnoses of Down Syndrome and Obsessive-compulsive disorder.</p> <p>During an interview on 02/29/24 at 02:55 PM, Staff I, Certified Nursing Assistant (CNA) explained when working with a resistant resident she would walk away, give the resident 5-10 minutes and re-approach the resident. If the resident continued to be resistant she asked a nurse to assist with the resident. Staff I stated if she witnessed a coworker getting a resistant response from a resident, she would ask the coworker to walk away, give the resident and coworker a couple of minutes, then re-approach the resident. Staff I stated they received annual training on dementia care, they have had a Liaison come to the facility for hands on training. All staff are required to complete mandatory Relias (online module training) yearly.</p> <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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/29/24 at 03:13 PM, the Director of Nursing (DON) stated she expected staff to walk away then consider re-approaching the resident if a resident was resistive to cares or requests. The DON also expected staff attempted to re-approach the resident 3 times then notified the nurse for assistance. The DON reported staff are required to complete dementia training and mandatory Relias training annually. The facility also had an in-service dementia training for staff to have a more hands on approach.		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972</p> <p>Based on observation, record review, staff and resident interviews, and policy review, the facility failed to appropriately implement interventions to protect the facility residents from possible abuse by not separating a staff member, allegedly heard verbally abusing a resident, from resident care in a timely manner and until a thorough investigation could be completed for 1 of 1 resident's (Resident #91). The facility reported a census of 117 residents.</p> <p>Findings include:</p> <p>Resident #91's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of Down Syndrome, intellectual disabilities, mood disorder, neuromuscular dysfunction of bladder, obsessive-compulsive disorder, and insomnia. The MDS identified a Brief Interview for Mental Status (BIMS) score of 2, indicating severely impaired cognition. Resident #91 exhibited behavioral symptoms not directed towards others and rejection of care one to three times in the seven-day look back period.</p> <p>Progress Note review did not show any documentation of the alleged incident on 1/26/24.</p> <p>Care Plan dated 12/28/23 review:</p> <p>The Care Plan Focus indicated Resident #91 had a behavior problem related to diagnoses of intellectual disabilities and obsessive compulsive disorder. It stated the resident verbalized false accusations towards staff when they set boundaries with him as directed by his guardian and the resident could be aggressive with his movements when angry. The interventions instructed staff to intervene as necessary to protect the rights and safety of others and to approach in a calm manner, remove from situation, and take to alternate location as needed.</p> <p>The Care Plan Focus indicated Resident #91 had impaired cognitive function and impaired thought processes related to Down Syndrome and intellectual disability. The interventions direct staff to cue and reorient resident as needed, keep the resident's routine consistent and try to provide consistent care givers and present just one thought, idea, or command at a time.</p> <p>The Care Plan Focus indicated Resident #91 had a mood problem related to diagnosis of obsessive compulsive disorder. The interventions direct staff to monitor mood to determine if problems seem to be related to external causes and monitor and report mood patterns, symptoms of depression or anxiety.</p> <p>Observations:</p> <p>On 2/26/24 at 2:43 PM, Resident #91 was observed sitting in the lounge area on [NAME] Place watching TV. He had a walker in front of him. He then got up to ambulate around the unit using his walker. He had a catheter bag in a privacy bag hanging from his walker. Resident #91 denied any concerns. He stated he liked it here and he liked the staff.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/27/24 at 2:14 PM, Resident #91 was observed ambulating in the hall of [NAME] Place using his walker. He was greeting others with a fist pump and a smile.</p> <p>On 2/28/24 at 3:04 PM, Resident #91 was observed sitting in the lounge area of [NAME] Place drinking a soda. He reached out to surveyor and requested a fist pump. He stated his sister had brought him soda and he expressed how much he liked it. He was pleasant and smiling at the time.</p> <p>Per the facility self-report documentation dated 1/26/24, at approximately 4:45 PM Staff L, Nurse Manager reported hearing a staff member say Well you don't want to piss me off to a resident. Staff L notified Staff M, Director of Nursing (DON). Staff M interviewed Staff N, Certified Nursing Assistant (CNA), who was the alleged perpetrator, and Staff L. Staff N reported he did not say that to the resident. Staff M stated Staff N was removed from his shift and sent home. An investigation was initiated.</p> <p>In an interview on 2/27/24 at 4:41 PM Staff O, Certified Medication Aide (CMA) , stated she had a concern that Staff L reportedly walked by [NAME] Place outside the door and heard Staff N tell Resident #91 to Fucking shut up. Staff L then went to [NAME] Place and talked to a Companion (a paid employee to help on the unit and with residents but do not provide direct care), and asked them to go to [NAME] Place. Staff L then went to confront Staff N on what she had heard. Staff O reported Staff L notified Staff M and allowed Staff N to return to care for the resident's on the unit. Staff O reported during the time of the alleged abuse Staff N was the only staff person on the unit. Staff O, reported her concern was that Staff L did not separate Staff N from the resident or remove him from resident care when she initially heard it and that Staff N was allowed to continue to work with the resident and other residents on the unit for 1-2 hours after the alleged verbal abuse. Staff O reports Staff N left a little before 7 PM and the alleged abuse happened 1-2 hours prior. She reported the facility pulled an aide from [NAME]Place to [NAME] Place to replace Staff N when he left around 7 PM.</p> <p>In an interview on 2/28/24 at 2:58 PM, Resident #115 stated he liked it at the facility and the staff treated him well and were kind and spoke to him in a kind and caring manner. He stated he had not heard any staff yell or talk to a resident in a disrespectful manner. Resident #155 had a BIMS score of 13 indicating intact cognition.</p> <p>In an interview on 2/28/24 at 3:19 PM, Staff P, Assistant DON, stated she was in the facility when the alleged verbal abuse occurred. She went to Staff L's office and was told of the incident in [NAME] Place where she heard Staff N talking to a resident in a disrespectful way. Staff L had heard the resident yelling something and then Staff N responded by saying something inappropriate. Staff L had already spoken to Staff N when she was notified of the incident. Staff P then called and spoke with Staff M and told her of the situation so she could intervene. She felt the time frame was short from the time Staff L had talked to Staff N and reported it to her. It was within 5 minutes that Staff P notified Staff M of the situation. Staff P was unsure how long Staff N continued to work on the unit. She stated she believed he was allowed on the household while interviews were being completed from what she read on the report. Staff N was eventually sent home that night and had not returned. She believed the incident happened in the later afternoon around 4:30 or 5:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/28/24 at 3:59 PM, Staff M, DON reported Staff L had notified Staff P and Staff P had notified her of the report. She stated she immediately went to Staff L's office to get her report. Based on what Staff L told her she went to [NAME] Place and pulled Staff N into the nurse manager office. Staff L had reported she heard Staff N say, Trust me (Res #91), you don't want to piss me off. Staff L thought that Staff N was by himself on the unit at the time and she would need to get supervision on the unit while she talked to him so she asked Staff Q, Life Enrichment Aide, from [NAME]Place to go to [NAME] Place to assist. Staff L stated she had asked Staff N to come to the entrance of [NAME] place to talk to her. Staff M stated she had met with Staff N earlier that day to give him a final warning for performance issues. When she heard what Staff L had reportedly heard Staff N say she thought it was enough to make her think it needed to be investigated. She reported that Staff Q stated she had heard the conversation in the entryway between Staff L and Staff N. Staff Q also heard Staff N say after it was over that Staff L was lucky he didn't punch her. Staff N had reported to Staff M that Staff L had put her hand in his face and was rude when talking to him. She reported taking Staff N to her office to wait while she watched the video (without sound) to see if that had occurred. It did not show Staff L ever putting her hand up in his face. She stated she then sent Staff N home pending the Department of Inspections, Appeals, and Licensing investigation. She felt Staff N was in the Nurse Manager's office for 45 minutes and then moved to her office for another 1-1.25 hours before being sent home. Staff M felt Staff N was probably on the unit for 15 minutes after the incident allegedly occurred. She stated it was the expectation staff be remove from the resident care area immediately when alleged abuse had occurred. She stated she thought it was Staff L's intention to bring Staff N over to discuss with him what had happened and what he said and then take action from there but he wasn't cooperative and she was uncomfortable so she left and notified Staff P. Staff M stated Staff N never worked in a resident care area after she removed him. She sent him home for the night and then after talking to Human Resources the following Monday, it was decided to terminate his position related to this incident and the other performance issues he had.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a phone interview on 2/28/24 at 4:13 PM, Staff L, Nurse Manager, stated she was sitting in her office right across from [NAME] Place and heard resident #91 yelling. She got up to check why he was yelling and just before she looked through the window to make sure no one was behind the door prior to entering, she heard Staff N say you don't want to piss me off and then heard Resident #91 yelling back at him. When she looked in the window, she the saw Staff N leaning against the medication cart looking at his phone. She felt Staff N was most likely the only staff person on the unit. She thought that Staff P who was on-call was probably in [NAME] place and when she went in there Staff P was not in the area. She then asked the activities person to go be with the resident while she talked to Staff N. She asked Staff N to come over by the door and he became agitated with her immediately. She told Staff N he could not talk to Resident #91 like that. Staff N denied saying anything to Resident #91. She stated Staff N got agitated with her and he was a big man and she felt threatened and uncomfortable so she chose to end the conversation with him. At that time she was unsure if there was other staff on the unit. She went back to her office and talked to Staff P and then Staff P called and talked to Staff M. Staff M came up to her office and she explained to what had happened. She felt that Staff N left the facility around 8:00 PM. She stated that he was allowed on the unit and was on the unit when she entered [NAME] place just before going home around 8 PM. She stated the incident happened around 4:45 PM and she called Staff P at 4:51 PM. She reported that Staff M took him to her office but that he was back on the unit around 8 PM and she had no idea how long he had been there and if he was allowed to continue to work with residents. The following Monday she reported she was relieved of her nurse manager position and put back on the floor as a floor nurse. She stated she felt Staff N should have been sent home immediately and that she could have separated him and removed him from the unit but she was not the nurse on-call and he didn't respect her and was aggressive towards her. She feels that she did everything she should have done and would not do anything differently.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a phone interview on 2/29/24 at 11:00 AM, Staff T, Homemaker, stated she was floating the evening of the incident in question. She reported she walked into [NAME] place in the middle of the incident and she right away noted Resident #91 to be sitting in the dining room at the table by the kitchen and the sink. His back was to the wall. He was sitting down and very distraught. He was rocking himself in the chair and screaming and [NAME]. She couldn't understand what he was saying but didn't think he was saying anything that made sense. She reported she was just standing there when Staff N walked in to the area. He entered from the left and was very visibly angry when he walked in. She stated his hands were balled into fist and straight at his side and he was stomping. She stated he then caught site of her, as he didn't know she had entered the household. He turned and walked away. He tried to calm down the best he could and then came back to Staff T and started venting to her and she asked him what happened. At that time the resident seemed to have calmed a little bit and was quieter. But not long after he started yelling and [NAME] again. Staff N got very angry and got in Resident #91's face and yelled at him Shut up! Shut up! Shut the fuck up!!! He then turned and stormed away. The resident immediately started crying. She tried to comfort the resident but he didn't want any part of that so she went into the kitchen when she was unable to calm him down. Just after that, Staff L entered the household and confronted Staff N about what she had heard, she told him she could hear him from outside the door and he could not talk to Resident #91 like that. She stated Staff N again stormed off. She was floating and had to go to another household but she saw Staff L start to walk after him. When Staff T came back later to [NAME] place, she saw Staff N in a closet talking to who she believed to be the Staff M. She came back and spoke to Staff N 3 times. After the first time, Staff N began venting to Staff T again about how bad his day had been. She stated she tried to keep the mood light as she wanted to stay out of it. She stated she felt the facility handled the situation quickly and professionally. She thought the incident happened around 4:00 PM and Staff M came and told him to get his stuff as he would need to go home around 6:15 PM. She reported that he was on the unit the entire time as she was in and out of the unit and he was there each time until he left to go home. She stated she believed he was still providing resident care but did not have much interaction with Resident #91 as he pretty much ignored him after that.</p> <p>In an interview on 2/29/24 at 4:09 PM, Staff Q, Life Enrichment Aide, stated she worked the evening of 1/26/24. She reported she started her shift in [NAME] place but then went to [NAME] place shortly after the start of her shift. She reported that Staff L came into [NAME] place and directed her to go back to [NAME] place. She stated she was told to return to [NAME] Place because Resident #91 was freaking out. She reported she went right over to [NAME] place at that time. She reported Resident #91 was sitting in the dining room of [NAME] Place when she entered. Shortly after that Staff L came in and pulled Staff N into the hallway by the exit door to talk to him. She stated she heard Staff L tell Staff N it is hard to talk to you as an adult. Staff N then stated, Speak to me as an adult when you are here talking to me like this? She stated shortly after that Staff N returned to the unit and Staff L left. She stated Staff N started venting to himself that he was done and going to leave and quit. He then realized he was the only CNA, so did not leave. She then heard him tell the medication passer that Staff L was lucky he didn't punch her in the face. Staff Q reported she stayed there for a little bit longer. Then Staff M came and took Staff N off the floor. She then went back to [NAME] Place but Staff L returned and asked her to go back to [NAME] place again and take Resident #91 for a walk. She reported that Staff N was back on the unit until about 6:30 PM when Staff M took him out. She stated she felt Resident #91 was having a bad day this date and was getting upset a lot. She did hear Staff N say (Res #91), calm down but she did not feel it was in a disrespectful manner.</p> <p>Review of the facility investigation revealed:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #91's emergency contact was his sister who is his guardian/conservator.</p> <p>Diagnoses include: Downs Syndrome, intellectual disabilities, mood disorder, neuromuscular dysfunction of the bladder, morbid obesity, obsessive compulsive disorder, hypothyroidism, obstructive sleep apnea, asthma, gastroesophageal reflux disease, urine retention, and pulmonary nodule.</p> <p>Facility write up: Staff L stated at approximately 4:45 PM she was sitting in her office and heard this resident screaming and yelling in anger over and over. She got up and walked to [NAME] Place and just before looking through the window she heard Staff N say Well you don't want to piss me off . Just as she looked through the window and saw Staff N leaning on the cart on his phone and she could hear the resident yelling back to him from the other side of the dining room. He saw Staff L looking through the window. She then walked over to [NAME] Place and asked the activity girl to go over to [NAME] because this resident was upset. She left [NAME] and went over to [NAME] Place. She then returned to [NAME] and asked Staff N to Come here I just need to talk to you real quick. He responded in a very short tone and said What! Staff L said to him, excuse me? She was unsure why he was taking such a short tone with her and then he changed his tone of voice and said, I just said what. She talked to him at [NAME] Place entrance because she couldn't remove him from the household. She then said to him Hey (Staff N), I can't have you talk to (Res #91) that way. He said, What way? and she said (Staff N), I heard you say to him 'Well you don't wanna piss me off' and he responded with I didn't say that, you must be hearing things and again he was taking a short tone and was defensive with her. He was making her feel uncomfortable and then she told him, Well I can't talk to you right now because you don't want to talk to me like an adult and you're just getting mad and yelling at me. He then yelled at her and said An adult. Like an adult. You're the one over there accusing me of saying stuff I didn't say . He continued to talk but she chose to walk out at that point because he was causing a scene.</p> <p>She called Staff P at 4:51 PM and reported to her what had happened. She wasn't sure where his primary nurse was and she was unaware if Staff M was still here or not. Staff P told her that she needed to let Staff M know what had happened because she had just talked to Staff N prior to his shift. She was sitting down to start typing the report and Staff M walked in and wanted to know what had just happened.</p> <p>Review of detail punches:</p> <p>Staff N punched in at 2:47 PM and punched out at 6:30 PM on 1/26/24. He did not work at all after that date until he was terminated from the facility on 1/29/24</p> <p>Staff L punched in at 8:13 AM and punched out at 6:01 PM on 1/26/24</p> <p>In an interview on 2/29/24 at 11:25 AM, the Administrator stated that per the facility Information Technology department, the video coverage in the facility is deleted at the end of each day and they no longer have the video coverage from the day of the alleged incident.</p> <p>Review of facility Human Resources employee files:</p> <p>a. Staff L was hired on 4/27/21 as a Licensed Practical Nurse (LPN).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Per signed Essential Functions dated 2/24/23 - She agreed to report any allegations of abuse, neglect, misappropriation of property, exploitation, or mistreatment of residents to supervisor and/or administrator. Protect residents from abuse, and cooperates with all investigation,</p> <p>-Completed Dependent Adult Abuse Mandatory Reporter Training 10/3/22 and was good for 3 years</p> <p>b. Staff N was hired on 8/31/22 and was a CNA</p> <p>- Had Relias training on Abuse policy assigned 11/3/23 and completed on 1/8/24 neglect and exploitation completed 8/8/23.</p> <p>-Completed Dependent Adult Abuse Mandatory Reporter Training 11/9/22 and good for 3 years</p> <p>In an interview on 2/29/23 at 4:40 PM, the Administrator and Staff M stated it was the expectation staff be taught to report any abuse or potential abuse to the abuse coordinator, administrator, or someone in management as soon as possible and the potential perpetrator was to be removed from resident care area as soon as possible until the investigation into the incident is completed. They stated the floor staff was to intervene at their comfort level but should definitely say something right away. They stated the nurse manager was expected to intervene at her comfort level as well. They are trained to separate if possible. Staff M stated she hoped a nurse manager would have enough responsibility to act immediately but if not, should notify management immediately.</p> <p>Review of Facility Policy: Abuse, Neglect and Exploitation last revised October 2023 stated [NAME] Life will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.</p> <p>Examples include but are not limited to:</p> <ul style="list-style-type: none"> - Responding immediately to protect the alleged victim and integrity of the investigation - Examining the alleged victim for any signs of injury, including a physical examination of psychosocial assessment if needed - Increased supervision of the alleged victim and residents - Room or staffing changes, if necessary, to protect the resident(s) form the alleged perpetrator - Protection from retaliation - Providing emotional support and counseling to the resident during and after the investigation, as needed - Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial need or preferences change as a result of an incident of abuse. 		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972</p> <p>Based on observation, clinical record review, staff interview, and policy review, the facility failed to develop a comprehensive person centered Care Plan for 1 of 6 residents reviewed for Pressure Ulcers (Resident #63). The facility reported a census of 117 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] recorded Resident # 63 admitted to the facility on [DATE]. The MDS identified the resident had diagnoses that included Parkinson's disease with dyskinesia, major depressive disorder, dementia, chronic pain, and polyneuropathy. Resident #63's MDS revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The MDS indicated the resident was totally dependent on staff for personal hygiene, toileting, bathing, and transferring, and required set up for eating. Resident was always incontinent of bowel and bladder. Resident had a pressure reducing device for his bed and chair and the resident was at risk for developing pressure ulcers.</p> <p>The Skin & Wound Pressure Area Documentation in the electronic health record revealed the pressure wound to the rear left thigh was first noted on 1/23/24 and was in-house acquired and noted to be unstageable. The wound had been assessed and measured weekly since that time. Measurements were as follows:</p> <p>1/23/24 - Area 0.71 cm², Length 1.3 cm and Width 0.74 cm</p> <p>1/30/24 - Area 0.53 cm², Length 1.15 cm and Width 0.67 cm</p> <p>2/6/24 - Area 0.17 cm², Length 0.51 cm and Width 0.46 cm</p> <p>2/13/24 - Area 0.68 cm², Length 1.35 cm and Width 0.74 cm</p> <p>2/21/24 - Area 1.55 cm², Length 2.14 cm and Width 1.05 cm</p> <p>2/28/24 - Area 0.3 cm², Length 0.6 cm and Width 0.1 cm</p> <p>Per the Orders Summary in the electronic health system the treatment to the area on Resident #63's left ischium was to cleanse the area with cleanser of choice, apply calcium alginate to wound bed, and cover with a hydrocolloid dressing every day shift and as needed for wound care.</p> <p>In an observation on 2/28/24 at 11:42 AM, Staff X, Registered Nurse (RN) and Staff Y, RN completed the treatment to the left ischial (thigh) pressure ulcer. Area was clean and without sign or symptoms of infection. The treatment was completed as ordered using good infection control techniques.</p> <p>Review of the Care Plan dated 6/29/21 with a revision date of 8/9/23 (most recent revision date) lacked a focus area related to the pressure ulcer identified on 1/23/24.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Bethany Life		STREET ADDRESS, CITY, STATE, ZIP CODE 212 Lafayette Street Story City, IA 50248	
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/29/24 at 1:53 PM, Staff Z, MDS Coordinator, stated the facility protocol was to have a Care Plan intervention in place within 72 hours and to put an intervention in place for staff immediately to address the issue. She stated pressure wounds were addressed on the Care Plan using the wording skin injury. She stated it was the expectation floor staff notify nurses or the care team of the area and they were to put interventions in place immediately and let the management team know of the new wound and a Care Plan focus was to be put in place within 72 hours of the wound being identified.</p> <p>The facility provide policy titled Comprehensive Care Plans dated 8/8/23 stated requests for revisions to the person-centered plan of care will be honored if appropriate. At a minimum, the care plan will be reviewed and revised by the team after each comprehensive and quarterly MDS. Responsible staff will be informed of the interventions that are identified in the care plan. They will receive notification initially and when changes are made.</p>		

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<p>F 0661</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873</p> <p>Based on record review and staff interview, the facility failed to complete a discharge summary including a recapitulation of stay for 1 of 3 discharged residents reviewed (Resident #117). The facility reported a census of 117 residents.</p> <p>The Census line portion of Resident #117's chart revealed the resident was admitted on [DATE] and discharged on [DATE].</p> <p>The Progress Note dated 12/5/23 at 2:51 pm documented a note that the resident discharged from the facility on that date. Her advocate came and picked her up in a personal vehicle. All personal items, her medications, and treatments as well as a list of appointments were sent with her.</p> <p>The resident's electronic health record failed to reveal a discharge summary or a post discharge plan of care.</p> <p>On 2/29/24 at 3:17 pm, the Administrator stated the recapitulation is done through the discharge progress note and the facility had no interdisciplinary form.</p> <p>On 3/5/24 at 7:32 am via email, the Administrator stated the facility does not have a policy on recapitulation of stay.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886</p> <p>Based on clinical record review, staff interview, and policy review, the facility failed to complete weekly skin assessments in accordance with the resident's comprehensive, person-centered Care Plan for 1 of 3 residents reviewed for skin conditions (Resident #62). The facility reported a census of 117 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) dated [DATE] documented Resident #62 had a Brief Interview for Mental Status (BIMS) of 3, indicating severe cognitive impairment. The MDS further documented the resident had diagnoses including non-traumatic brain dysfunction, diabetes mellitus, and non-Alzheimer's dementia.</p> <p>The Care Plan for Resident #62, revised 11/25/22 with a focus area for Activities of Daily Living (ADL), directs staff under the interventions and task area to complete a skin inspection weekly.</p> <p>Review of electronic health records (EHR) for weekly skin assessments for Resident #62 revealed lack of documentation of skin assessments for the weeks of 1/17, 1/24, 1/31, 2/7 and 2/14 in the year of 2024, and from 1/11 to 5/24, 6/7, 6/21, 8/16, 9/6, 9/13 and 9/27 in the year of 2023. Further review of the EHR for Resident #62 showed an order from the resident's primary physician on 9/28/2022 for a Skin & Pain Assessment in the evening every Wednesday; complete a head to toe skin assessment, question related to pain and document in progress notes. Complete total skin assessment form in Point Click Care (PCC). If new areas found, complete risk management and picture in PCC.</p> <p>During an interview 2/27/24 at 2:59 PM, Staff K, certified medication aide (CMA), advised Resident #62 should have a skin assessment completed weekly. The nursing staff complete the skin assessments after or during the shower, which for this resident is on Wednesdays and Saturdays.</p> <p>During an interview 2/27/24 at 4:38 PM, the Director of Nursing (DON) verified Resident #62 should have weekly skin assessments completed and documented and will follow up on the missing documentation.</p> <p>During an interview 2/28/24 at 10:30 AM, the DON stated on the dates the weekly skin assessment was not documented, the CMA working marked on the treatment administration record (TAR) that the assessment was completed, which then did not trigger for the nursing staff to complete the skin assessment report. Only nursing staff can complete the skin assessments and they complete the skin assessment for the resident on their first shower day of the week, which for Resident #62 is on Wednesdays. The skin assessment report was not completed for the weeks the skin assessments are missing in the electronic health record. The DON advised she has an expectation that weekly skin assessments be completed and documented fully.</p> <p>Review of the facility Skin Assessment Policy, with a review date of 9/25/23, instructed staff under the procedure section to document the skin assessment, including the date and time, staff name and position title, observations, wound measurements and type, if resident refused assessment and why and other information as indicated or appropriate.</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<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** 48886</p> <p>Based on observation, clinical record review, staff interviews and policy review, the facility failed to ensure each resident receives adequate supervision to prevent accidents for 1 of 2 residents reviewed for falls (Resident #103). The facility reported a census of 117 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) dated [DATE] documented Resident #103 had a Brief Interview for Mental Status (BIMS) of 4, indicating severe cognitive impairment. The MDS further documented the resident had diagnoses including fractures and other multiple trauma, hip fracture and non-Alzheimer's dementia.</p> <p>Review of medical records from a local Medical Center, dated [DATE] for Resident #103, under history of present illness, documented the resident had an unwitnessed fall on [DATE] at the facility which resulted in a left hip fracture.</p> <p>The Care Plan for Resident #103 at the time of the fall on [DATE], with initiation dates of [DATE] and [DATE], documented under the focus area for activities of daily living (ADL), the resident had an ADL self-care performance deficit related to a right hip fracture. Under the interventions and tasks area, under ambulation, the resident was an assist of one staff with a front-wheeled walker (FWW). Under transfer, the resident was an assist with one staff with the FWW. Under gait belt, staff are instructed to follow facility protocol as resident allows for gait belt usage. Resident #103 had a focus area stating she had impaired cognitive function/dementia or impaired thought processes related to dementia and under interventions and tasks, directed staff to cue, reorient and supervise as needed.</p> <p>During an observation [DATE] at 1:30 PM of the household where Resident #103 resides (Julia's Place), the layout of the household included a locked entry door, which entered into a main family room with a smaller family room in the back, the kitchen and dining areas were to the right of the family room and a long hallway to the left of the family room which housed the resident rooms. The entirety of the hallway with the resident rooms could not be viewed from the dining room, the kitchen, or the family room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview [DATE] at 2:30 PM, Staff K, certified medication aide (CMA), advised she had worked at this facility in Julia's Place household for several years, normally the 7:00 AM to 3:00 PM shift. Staff K stated they are short staffed often on this unit, to be fully staffed they need a CMA or nurse for medication pass, two certified nursing assistants (CNA's) and a homemaker (the homemaker does the kitchen and dining duties). They normally only have one CNA and one CMA, several times they do not have a homemaker and it is just her as a CMA and one CNA working. When it is just her and a CNA working she is trying to do medications and gets pulled into CNA work. She needs to assist the CNA and do CNA work on top of medications, which can be challenging. During these times when they are short staffed it is difficult to get to residents as quickly as they want to, especially if a resident is a two person assist or a mechanical lift. Staff K advised it is challenging when they are short staffed given their population on this household and needing to redirect residents who walk without their walkers or who wander into other resident's rooms. The layout of the unit also makes it difficult to observe the entire unit, with a long hallway with resident rooms and the kitchen and dining area on the other side and the family rooms in the middle, however if a staff is in the dining room or family room, they cannot see down the hallway where the resident rooms are located. Staff K was not working on the date and time Resident #103 fell .</p> <p>During an interview [DATE] at 2:30 PM, Staff R, certified nursing assistant (CNA), advised she was working the day Resident #103 fell , on the 22nd of December, 2023. The fall took place during dinner time. At that time the resident was a 1 person assist with her walker. Staff R advised the resident would normally use her walker, she would not very often get up without using it, however she would get up without waiting for staff to assist her with the gait belt, and assist her with walking. At the time of the fall, it was just Staff R working and a CMA and a homemaker- the homemaker was new and had several questions for Staff R. Staff R stated to be sufficiently staffed on this household, which is a chronic confusion or dementing illness (CCDI) unit with 15 residents, they need 2 CNA's, one CMA, a homemaker, and a registered nurse (RN) who floats. At the time of the fall, they only had 1 CNA, 1 CMA, and a new homemaker. They were just starting to serve dinner and Resident #103 did not have her dinner yet, she was sitting at the table, however she got up and left the table before being served her dinner. Staff R advised the resident was more restless in the evening and had more behaviors in the evenings. She would move around often. Resident #103 got up from the table without a gait belt assist and walking assistance and left the dining room. Staff R advised she could not follow the resident because she was the only one in the dining room and she needed to supervise the other residents, they have residents who are Care Planned to have supervision while eating. She asked the resident to come back to the table, however the resident continued to walk with her walker and went through the family room and turned to go down the resident room hallway, which cannot be observed from the dining room due to the layout of the unit. The CMA working at the time was in another resident's room giving medications. A little while later, another resident came into the dining room and told Staff R that Resident #103 was on the ground in the hallway of the resident's rooms. Staff R went down to the hallway and found the resident on the floor. She yelled out for the CMA and she and the CMA lifted the resident off the ground with a mechanical lift. They immediately called for the nurse who came within a few minutes and called for an ambulance.</p> <p>Staff R advised the next day after the fall she told her scheduler that she did not want to work a shift with just one CNA and one CMA, the scheduler told her that this was going to happen and did schedule her again to work with just a CMA and not another CNA. Staff R told the scheduler she did not feel safe working without another CNA. Staff R felt if they would have been fully staffed the night Resident #103 fell they could have prevented the fall as they could have redirected her back to the dining room and given her the 1 person assist with ambulating and supervision.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview [DATE] at 2:50 PM, Staff S, CMA, advised she had worked here for a total of [AGE] years, solidly for the past [AGE] years. She moves around to different households and varying shifts. She was working as a CMA the day Resident #103 fell , this was during dinner time. At that time, the resident used a walker to ambulate and was a one person assist, she was non-compliant at times and would get up without waiting for a gait belt assist and did not want anyone helping her. The night Resident #103 fell , Staff S was passing medication and had just looked down the hallway and the resident was not there, she was in the dining room. At the time of the fall, it was just Staff S and one CNA working with a homemaker, they did not have a 2nd CNA. Staff S said they should always have a 2nd CNA, especially due to this population on the CCDI unit and especially in the evening with sundowning (referring to an increase in confusion/behaviors in the evening, after sundown) and more behaviors and restlessness. Staff S said there have been several times that she has worked on this unit/household and there has only been 1 CNA and one CMA and a homemaker, and sometimes just 1 CNA, a CMA, and no homemaker, only two staff working. Staff S stated this creates a challenging and difficult situation, and she feels an unsafe situation, when they are not sufficiently staffed. It is hard to meet the residents needs and it is hard for her to pass medications and do CNA work, or homemaker worker in the kitchen. Staff S could not recall specifically where she was or what resident's room she was in when the resident fell that day, she only recalls she was passing medication.</p> <p>During an interview [DATE] at 3:44 PM, the Administrator and Director of Nursing (DON) advised normal and sufficient staffing on Julia's Place household is a CMA, a homemaker, 2 CNA's during the day and a nurse who floats between households. During the 2:00 PM -10:00 PM shift, normal and sufficient staffing is a CMA, 2 CNA's until 7:00 PM, a homemaker and floating nurse. The DON stated Resident #103 came to them as high risk with a prior hip fracture and was not compliant at all times. The DON does not feel supervision was a concern at the time of the fall, or adequate staffing, even though she acknowledged they only had 1 CMA and 1 CNA and a homemaker working at the time, it was dinnertime and before 7:00 PM, the household did not have a 2nd CNA at the time of the fall. The DON advised she was informed during her interviews after the fall that the CMA was in the dining room, not that she was passing medications. The DON and Administrator acknowledge supervision needs to take place while residents are eating, some residents on this household have this on their Care Plan. The DON felt the homemaker could help with supervision, even while getting food ready and even though they are not CNA trained or CPR certified.</p> <p>Review of the Facility Assessment, updated July of 2023, under general care- specific care or practices, documents hazards and risks for residents will be identified, care and services will be based on resident population, including assistance with activities of daily living and mobility assistance, mobility and fall/fall with injury prevention.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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** 46873</p> <p>Based on facility record review, resident and staff interviews, the facility failed to maintain an adequate number of staff for the facility's census to provide needed care and supervision of all residents. The facility reported a census of 117 residents.</p> <p>Findings include:</p> <p>1. On [DATE] at 3:14 pm, Resident #32 reported the facility does not have enough help. She stated at times she has to wait a long time to receive assistance.</p> <p>On [DATE] at 8:06 am, Resident #100 stated she voices her concerns to the facility. She reported the facility is short staffed and feels its too large of a facility.</p> <p>On [DATE] at 9:09 am, Resident #14 stated the facility never has enough staff.</p> <p>On [DATE] at 10:59 am, Staff AA, Licensed Practical Nurse (LPN) reported that one of the units houses 18 residents and the normal staff is one nurse and one CNA. She stated she is asked daily to pick up extra shifts. She stated on the two dementia units on the second floor, there is never more than one CNA.</p> <p>On [DATE] at 11:10 am, Staff I, CNA stated she feels like the facility is understaffed. She stated every day she is asked to work extra shifts. She emphasized she feels confident in the staff that work at the facility, but that it is not fair to the residents to be so short staffed. She said it's not OK to have only a medication aide and a CNA and no homemaker. She reported it is very hard to have only two people to make the resident's dinner trays and serve them and she cannot leave the dining room if someone else needs help. She said that at times if management is called for assistance they do not answer their phones.</p> <p>On [DATE] at 4:14 pm, the Administrator stated the facility is consistently working on hiring people. She said it is ongoing and a hall is never left unsupervised. She stated there is always at least two staff members on every unit and nurse managers jump in and help when there is not enough staff. She stated the facility staff would rather work overtime than have staffing agency employees in the facility.</p> <p>The Facility Assessment, updated date of July, 2023 documented a Staffing Plan Matrix of ,d+[DATE] staff members per 24 hours including nurses, CNAs and CMAs to care for the residents on a daily basis.</p> <p>Review of 30 days of Staff/Census posting sheets dated [DATE]- February 17, 2024 revealed on 14 of those 30 days there was 45 or few staff to care for the residents in a 24 hour period of nurses, CMAs, and CNAs. The census during these days ranged from ,d+[DATE] residents.</p> <p>48886</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 - Many</p>	<p>2. The Minimum Data Set (MDS) dated [DATE] documented Resident #103 had a Brief Interview for Mental Status (BIMS) of 4, indicating severe cognitive impairment. The MDS further documented the resident had diagnoses including fractures and other multiple trauma, hip fracture and non-Alzheimer's dementia.</p> <p>Review of medical records from a local Medical Center, dated [DATE] for Resident #103, under history of present illness, documented the resident had an unwitnessed fall on [DATE] at the facility which resulted in a left hip fracture.</p> <p>During an interview [DATE] at 2:30 PM, Staff K, certified medication aide (CMA), advised she has worked at this facility in Julia's Place household for several years, normally the 7:00 AM to 3:00 PM shift. Staff K stated they are short staffed often on this unit, to be fully staffed they need a CMA or nurse for medication pass, two certified nursing assistants (CNA's) and a homemaker (the homemaker does the kitchen and dining duties). They normally only have one CNA and one CMA, several times they do not have a homemaker and it is just her as a CMA and one CNA working. When it is just her and a CNA working she is trying to do medications and gets pulled into CNA work. She needs to assist the CNA and do CNA work on top of medications, which can be challenging. During these times when they are short staffed it is difficult to get to residents as quickly as they want to, especially if a resident is a two person assist or a mechanical lift. Staff K advised it is challenging when they are short staffed given their population on this household and needing to redirect residents who walk without their walkers or who wander into other resident's rooms. The layout of the unit also makes it difficult to observe the entire unit, with a long hallway with resident rooms and the kitchen and dining area on the other side and the family rooms in the middle, however if a staff is in the dining room or family room, they cannot see down the hallway where the resident rooms are located. Staff K was not working on the date and time Resident #103 fell . Staff K advised she worked by herself yesterday from 2:00 PM to 3:00 PM on the unit; the unit has 15 residents.</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 - Many</p>	<p>During an interview [DATE] at 2:30 PM, Staff R, certified nursing assistant (CNA), advised she was working the day Resident #103 fell , on the 22nd of December, 2023. The fall took place during dinner time. At that time the resident was a 1 person assist with her walker. Staff R advised the resident would normally use her walker, she would not very often get up without using it, however she would get up without waiting for staff to assist her with the gait belt, and assist her with walking. At the time of the fall, it was just Staff R working and a CMA and a homemaker- the homemaker was new and had several questions for Staff R. Staff R stated to be sufficiently staffed on this household, which is a chronic confusion or dementing illness (CCDI) unit with 15 residents, they need 2 CNA's, one CMA, a homemaker and a registered nurse (RN) who floats. At the time of the fall, they only had 1 CNA, 1 CMA, and a new homemaker. They were just starting to serve dinner and Resident #103 did not have her dinner yet, she was sitting at the table, however she got up and left the table before being served her dinner. Staff R advised the resident was more restless in the evening and had more behaviors in the evenings. She would move around often. Resident #103 got up from the table without a gait belt assist and walking assistance and left the dining room. Staff R advised she could not follow the resident because she was the only one in the dining room and she needed to supervise the other residents, they have residents who are Care Planned to have supervision while eating. She asked the resident to come back to the table, however the resident continued to walk with her walker and went through the family room and turned to go down the resident room hallway, which cannot be observed from the dining room due to the layout of the unit. The CMA working at the time was in another resident's room giving medications. A little while later, another resident came into the dining room and told Staff R that Resident #103 was on the ground in the hallway of the resident's rooms. Staff R went down to the hallway and found the resident on the floor. She yelled out for the CMA and she and the CMA lifted the resident off the ground with a mechanical lift. They immediately called for the nurse who came within a few minutes and called for an ambulance.</p> <p>Staff R advised the next day she told her scheduler that she did not want to work a shift with just one CNA and one CMA, the scheduler told her that this was going to happen and did schedule her again to work with just a CMA and not another CNA. Staff R told the scheduler she did not feel safe working without another CNA. Staff R stated there have been several shifts that she had worked in the last several months where it was just her and a CMA. She works different shifts, the morning shift and evening shift and this has happened on both shifts, where it is just her and a CMA and a homemaker, they do not have the extra CNA. Sometimes, there is no homemaker and Staff R will have to do homemaker duties as well, which is setting up the food for meals and serving the food and cleaning the kitchen. On several weekends in the last month it is just her and a CMA, no homemaker and no 2nd CNA, just two people working. Staff R stated residents have to wait longer for cares and assistance and it is more difficult to monitor and redirect, they have several residents who wander and have behaviors on this CCDI unit. Staff R felt if they would have been fully staffed the night Resident #103 fell they could have prevented the fall as they could have redirected her back to the dining room and given her the 1 person assist with ambulating.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Bethany Life		STREET ADDRESS, CITY, STATE, ZIP CODE 212 Lafayette Street Story City, IA 50248	
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview [DATE] at 2:50 PM, Staff S, CMA, advised she has worked here for a total of [AGE] years, solidly for the past [AGE] years. She moves around to different households and varying shifts. She was working as a CMA the day Resident #103 fell , this was during dinner time. At that time, the resident used a walker to ambulate and was a one person assist, she was non-compliant at times and would get up without waiting for a gait belt assist and did not want anyone helping her. The night Resident #103 fell , Staff S was passing medication and had just looked down the hallway and the resident was not there, she was in the dining room. At the time of the fall, it was just Staff S and one CNA working with a homemaker, they did not have a 2nd CNA. Staff S said they should always have a 2nd CNA, especially due to this population on the CCDI unit and especially in the evening with sundowning (referring to increased confusion/behaviors in the evening, after sundown) and more behaviors and restlessness. Staff S said there have been several times that she has worked on this unit/household and there has only been 1 CNA and 1 CMA, and a homemaker, and sometimes just 1 CNA, a CMA and no homemaker, only two staff working. Staff S stated this creates a challenging and difficult situation, and she feels an unsafe situation, when they are not sufficiently staffed. It is hard to meet the residents needs and it is hard for her to pass medications and do CNA work, or homemaker worker in the kitchen. Staff S could not recall specifically where she was or what resident's room she was in when the resident fell that day, she only recalls she was passing medication.</p> <p>During an interview [DATE] at 3:44 PM, the Administrator and Director of Nursing (DON) advised normal and sufficient staffing on Julia's Place household is a CMA, a homemaker, 2 CNA's during the day and a nurse who floats between households. During the 2:00 PM -10:00 PM shift, normal and sufficient staffing is a CMA, 2 CNA's until 7:00 PM, a homemaker and floating nurse. The DON stated Resident #103 came to them as high risk with a prior hip fracture and was not compliant at all times. The DON does not feel supervision was a concern at the time of the fall, or adequate staffing, even though she acknowledged they only had 1 CMA and 1 CNA and a homemaker working at the time, it was dinnertime and before 7:00 PM, the household did not have a 2nd CNA at the time of the fall. The DON advised she was informed during her interviews after the fall that the CMA was in the dining room, not that she was passing medications. The DON and Administrator acknowledge supervision needs to take place while residents are eating, some residents on this household have this on their Care Plan. The DON felt the homemaker could help with supervision, even while getting food ready and even though they are not CNA trained or CPR certified.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>34817</p> <p>Based on observation, staff interviews, facility policy review, and the Center for Disease Control (CDC) guidelines the facility staff failed to ensure liquid Lorazepam (a sedative /controlled substance) stored in a locked compartment in the refrigerator for 2 of 4 medication rooms reviewed. The facility also failed to maintain safe operating equipment and ensure medication refrigerators were kept clean and maintained to prevent ice build-up in the freezer in order to ensure safety and efficacy of medications and vaccines for 2 of 4 medication refrigerators reviewed. The facility reported a census of 117 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observations of the Lifebridge household medication room on 2/28/24 at 4:17 PM with Staff A, Registered Nurse (RN), revealed a 30 milliliter (ml) bottle of liquid Lorazepam stored inside an unlocked medication refrigerator. 2. During observation of the David's Place household medication room on 2/28/24 at 4:50 PM with Staff B, RN, revealed four 30 ml bottles of liquid Lorazepam inside an unlocked refrigerator. At the time, Staff B reported CMA's and nurses had a key to the medication room and able to obtain medication from the medication room and medication refrigerator. 3. During observation of the Lifebridge medication refrigerator on 2/29/24 at 8:39 AM with Staff C, CMA, revealed the medication refrigerator unlocked and had a 30 ml bottle of liquid Lorazepam inside the medication refrigerator. <p>In an interview 2/29/24 at 8:39 AM, Staff C reported the medication refrigerator had a lock on it but it depended on if they had a medication that had to be locked up or not. The surveyor asked Staff C if Lorazepam needed locked up. Staff C reported Lorazepam should be locked up. When the surveyor showed Staff C the box labeled Lorazepam and bottle of liquid Lorazepam inside, Staff C said she was unaware of the Lorazepam in the refrigerator. Staff C stated she had to get a key to lock the medication refrigerator, but the nurse had to come to the unit to lock the medication refrigerator.</p> <p>In an interview 2/29/24 at 11:20 AM, Staff G, maintenance, reported staff put in a work order if something needed repaired. Staff G reported no work orders received in a very long time to repair medication refrigerators.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview 2/29/24 at 3:24 PM, the Director of Nursing (DON) reported liquid Lorazepam and other controlled substances requiring refrigeration needed to be double locked and kept in the medication refrigerator. The DON reported staff had trouble with the medication refrigerator lock and had to get new keys to lock the medication refrigerator on the Lifebridge household.</p> <p>A facility's Controlled Substance Count policy updated 9/25/23 revealed narcotic medication kept under two locks at all times. A refrigerated narcotic medication kept in a locked room in a locked refrigerator.</p> <p>4. Observations revealed the following:</p> <p>The Lifebridge household unit medication room with Staff A, Registered Nurse, on 2/28/24 at 4:17 PM, revealed a refrigerator contained various medications including a bottle of liquid Lorazepam, 11 syringes of flu vaccines, tuberculin purified protein derivative (for TB skin test), insulin, and Vancomycin (antibiotic). The freezer compartment had a heavy build-up of ice inside.</p> <p>On 2/29/24 at 8:18 AM, the medication refrigerator kept in the medication room on David's Place had a large amount of ice buildup in the freezer compartment. The refrigerator contained various medications.</p> <p>In an interview 2/29/24 at 8:39 AM, Staff C, CMA, reported the medication refrigerator to be cleaned by the household's homemaker.</p> <p>In an interview 2/29/24 at 8:45 AM, Staff D, homemaker, reported she served meals and cleaned out the refrigerator in the kitchenette and household unit, but she did not clean the medication refrigerator. Staff D stated she thought the nurses cleaned the medication refrigerator.</p> <p>In an interview 2/29/24 at 8:50 AM, Staff C, CMA, now reported she thought the housekeeper cleaned the medication refrigerator. Staff C acknowledged she wasn't aware of the ice buildup in the medication refrigerator but she would let someone know to defrost and clean the medication refrigerator.</p> <p>In an interview 2/29/24 at 11:00 AM, Staff E, housekeeper, reported he was unsure who cleaned the medication refrigerators on the households.</p> <p>In an interview 2/29/24 at 11:10 AM, Staff F, housekeeper, reported she was uncertain who cleaned the medication refrigerators. She had only worked at the facility for two months, and needed to check with her manager.</p> <p>In an interview 2/29/24 at 11:20 AM, Staff G, maintenance, reported he had worked at the facility 2 1/2 years. Staff G stated he only worked on the medication refrigerator if he got a work order for repairs and if it needed defrosted. Staff G confirmed he had not received any work orders for medication refrigerators in a very long time. Staff G stated he thought maybe the nursing staff defrosted and cleaned the medication refrigerators.</p> <p>During an interview 2/29/24 at 11:35 AM, the Director of Support Services (housekeeping and maintenance) reported the housekeepers didn't do anything with the household medication refrigerators. The nursing staff cleaned and defrosted the medication refrigerators.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview 2/29/24 at 3:24 PM, the DON reported the maintenance department cleaned and defrosted the household medication refrigerators. The DON reported staff submitted a work order or verbally told the maintenance staff whenever the medication refrigerator needed cleaned and defrosted.</p> <p>An email from the Administrator on 3/4/24 at 8:31 AM, revealed the facility didn't have a policy for medication refrigerator cleaning.</p> <p>The CDC guidelines revealed the following:</p> <p>https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf</p> <p>Under section three: vaccine storage and temperature monitoring equipment:</p> <p>a. It is important the facility maintained and repaired equipment appropriately and as needed in order to ensure proper operation and to protect residents from inadvertently receiving compromised vaccine/medication.</p> <p>b. Vaccines must be stored properly. Potency is reduced every time a vaccine is exposed to an improper condition including overexposure to cold.</p> <p>c. Defrost manual-defrost freezers when the frost exceeds either 1 centimeter or the manufacturer's suggested limit.</p> <p>The thin layers of frost on the inside of a freezer will not affect a freezer's performance, but a thick layer may affect the freezer's ability to maintain cold temperatures. Cold temperature storage may affect the efficacy and safety of vaccines and medications. Regularly defrosting a freezer minimizes the risk of damage to vaccines.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>48886</p> <p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, staff interviews, and facility policy review, the facility's Dietary Staff failed to perform the proper functions of food and nutrition services for the pureed food process for 7 of 7 residents requiring a pureed diet. The facility reported a census of 117 residents.</p> <p>Findings include:</p> <p>During an observation 2/28/24, beginning at 9:00 AM and ending at 11:15 AM, Staff J, cook, began the puree process for 7 residents on a pureed diet for lunch service on this date. Staff J began the process to puree green beans, adding unmeasured beans into the blender, then adding hot water and thickener. After pureeing the green beans, Staff J did not measure out the volume of green beans pureed, she used a spread sheet already prepared to determine the scoop size for each resident, a #4 scoop.</p> <p>Staff J then began the process to puree the beef and noodle mixture, stating she put 8 servings into the blender using the #6 scoop. Staff J added 3 cups of hot water into the blender, then added thickener. After pureeing the beef and noodles, Staff J did not measure the volume pureed, rather used a spread sheet already prepared to determine the scoop size for each resident, a #6 scoop.</p> <p>Staff J then began the process to puree the caramel apple desert, using the #12 scoop to scoop out 8 servings into the blender, then added apple juice. Staff J did not measure the volume pureed, rather used a spread sheet already prepared to determine the scoop size for each resident, a #12 scoop.</p> <p>Staff J then began the process to puree the grilled cheese sandwiches, placing 10 sandwiches into the blender. Staff J added 2 1/2 cups of hot water, then 3 more cups of hot water, then 2 more cups of hot water, then thickener. Staff J did not measure the volume pureed, rather used a spread sheet already prepared to determine the scoop size for each resident, a #6 scoop.</p> <p>During an interview 2/28/24 at 9:20 AM, Staff J advised she does not measure the volume of pureed food after pureeing, she uses the scoop on the spread sheet already prepared for the type of food being pureed. Staff J stated she does not use the graph to determine the scoop size, she uses the spread sheet.</p> <p>During an interview 2/29/24 at 9:10 AM, the Dietician advised kitchen staff should portion out the servings before placing the food item into the blender to puree, and they should use only fluids that add nutritional value to the puree, such as broth, milk or juice, they should not add water. A spread sheet is prepared beforehand with the scoop size to use after the puree process, however staff should measure the volume after pureeing to be sure they have the correct serving size scoop and change the scoop size if needed. The Dietician stated an expectation of the pureed food to be measured after the puree process and to use the graph to determine the scoop size. She further stated an expectation that staff use appropriate fluids to add to the puree, water is not an appropriate fluid. The Dietician acknowledged the process observed on 2/28/24 for the pureeing of lunch service was not completed according to their puree policy and guidelines. The Dietician advised she has observed kitchen staff puree appropriately and they are trained on the puree process.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Puree Food Preparation Policy, dated 9/25/23, under the procedure section directs staff to measure out desired number of servings into container for pureeing, add any necessary thickener or appropriate liquid of nutritive value and flavor to obtain desired consistency, measure the total volume of the food after it is pureed, use the Puree Scoop Outline for Pureed Diet Portions Sizes/Dishes and notify household staff if portion size is different than the spreadsheet for the food item.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>34817</p> <p>Based on observation, resident and staff interview, and facility policy review the facility failed to prepare and serve all foods at a safe and palatable temperature in order to prevent food-borne illness for 1 of 6 households observed (Sansgaard Household). The facility reported a census of 117 residents.</p> <p>Findings include:</p> <p>During initial resident screening of Sansgaard household residents on 2/26/28 to 2/27/28, 2 of 10 interviewable residents reported food temperatures are often not hot when meals are served. It was rare to get hot food.</p> <p>During observation in the Sansgaard household on 2/28/24 at 11:45 AM, Staff D, homemaker, checked the food temperatures of each entree she planned to serve during the lunch meal service. The food temperatures revealed the following:</p> <p>Grilled cheese sandwich - 140 degrees Fahrenheit (F)</p> <p>Tomato soup - 166 degrees F</p> <p>Green beans - 158 degrees F</p> <p>Hamburger patties -131.5 degrees F</p> <p>The following pans of food sat on top of the stove but not on the burner for warming included:</p> <p>Noodles - 131 degrees F</p> <p>Ground beef noodles - 110 degrees F</p> <p>Pureed green beans -100.3 degrees F</p> <p>On 2/28/24 at 12:04 PM, Staff D began to plate food for resident's located in the Sansgaard household.</p> <p>At 1:03 PM, Staff D reported the last resident was served.</p> <p>At 1:05 PM, Staff D checked the food temperatures of the remaining food. The ending food temperatures revealed the following:</p> <p>Grilled cheese sandwich - 130 degrees F</p> <p>Green beans -138 degrees F</p> <p>Soup -152 F</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Hamburger patties -115 degrees F</p> <p>Fortified mashed potatoes -108 degrees F</p> <p>During an interview 2/28/24 at 1:15 PM, Staff D reported she had worked as a homemaker since 8/2023. She normally worked in another household but she was assigned to work in the Sansgaard Household on 2/28/24. Staff D reported food came from the main kitchen but she checked temperatures on the food before the meal was served, and again when the last resident was served on the household for the food entrees kept. Staff D stated food temperatures should be at the temperature on the chart kept on each household, and it depended on what type of food was served. For example, if chicken, beef, fish, or other entree served, the temperature varied. Staff D reported she didn't know where the temperature chart was kept in the Sansgaard household.</p> <p>Random resident interviews of residents residing on the Sansgaard household on 2/28/24 at 1:20 PM to 01:47 PM, one of four residents reported she received a room tray. Her soup was cold and the grilled cheese sandwich was not hot.</p> <p>The facility's Food Temperature policy dated 10/27/22 directed the following: All hot food items served at least 140 degrees F. Foods failing to register this temperature must be reheated until acceptable temperatures are reached. If food required reheating, it must be treated as a leftover and heated to 165 degrees F. The cook shall monitor adequate heating time for plates and the steam table line system so that temperatures are maintained during the serving process.</p> <p>During an interview 2/29/24 at 3:09 PM, the Dietician reported food prepared and food temperatures checked in the main kitchen, then food transported to the households. Food temperatures checked again prior to food served in the households. The Dietician reported the food not sent out to the households if food is not up to the proper temperature until it is up to at least 140 degrees F or above. The dietician reported she expected food temperature at 140 degrees F or above before the food served during a meal service. If the food temperatures less than 140 degrees F she expected staff reheat the food to 165 F before serving.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49990</p> <p>Based on direct observation and staff interviews, the facility failed to provide appropriate catheter cares as it relates to 1 of 26 residents sampled (Resident #91). The facility reported a census of 117.</p> <p>Findings include:</p> <p>Review of Resident #91's Care Plan dated 12/22/24, which showed diagnoses of Down Syndrome with intellectual disability and Neurological dysfunction of bladder requiring suprapubic catheter.</p> <p>Review of Resident #91's Minimum Data Set (MDS) dated [DATE] which showed a Brief Interview for Mental Status (BIMS) score of 2, suggesting severely impaired cognition. MDS noted the presence of an indwelling catheter.</p> <p>Direct observation on 02/29/24 at 12:42 PM of Staff H (CMA) returning Resident #91 back to the unit after an appointment. At that time a significant length of catheter tubing was seen dragging on the ground, with Resident #91 stepping on it three times as he was escorted to his room. While Staff H actively assisted Resident #91 to their room, they took no action to correct the issue with catheter tubing.</p> <p>Interview on 02/29/24 at 2:48 PM with Staff B (RN), who noted at that time that proper catheter care is to secure the catheter tubing to the resident's leg, and place the remaining tubing in a dignity bag. Staff B further noted that Resident #91 often resists cares, including catheter cares, and that they secure long lengths of catheter tubing in the dignity bag as Resident #91 will not tolerate securing bags or tubing to their leg.</p> <p>Interview on 02/29/24 at 2:54 PM with Staff X (RN), who also noted that Resident #91 resists cares and will not tolerate anything touching their leg. Staff X reiterated what Staff B had said, they place excess catheter tubing in the dignity bag and secure it there to remove potential hazards. Staff X noted Resident #91 had never resisted placement of catheter tubing in the dignity bag to their knowledge.</p>		