| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165424 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethany Life | 212 Lafayette Street<br>Story City, IA 50248 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on clinical record reviews, staff interviews, resident interview and policy review, the facility failed to provide adequate nursing supervision to prevent accident and injuries for 2 of 4 residents reviewed (Resident #12 and #50). 1. A - On 11/21/25 Resident #12 received a second degree burn from a hot pack which took almost 2 months to heal. 1. B - Resident #12 had an intercepted fall on 1/3/26 which resulted in a left foot injury. 2. On 2/11/26 Resident #50 had a fall due to a staff member letting go of the gait belt. The facility reported a census of 102 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #12 dated 10/22/25 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS identified Resident #12 required substantial/maximal assistance with bed mobility and was dependent on staff for all transfers. The MDS documented ambulation did not occur. The MDS included diagnoses of moderate persistent asthma, COPD (chronic obstructive pulmonary disease) (a progressive, incurable lung disease that restricts airflow), spinal enthesopathy of thoracic and cervical region (painful condition involving inflammation or degeneration), congestive heart failure (heart cannot pump blood efficiently causing fluid buildup), major depressive disorder and anxiety.The Care Plan revised 2/26/24 revealed Resident #12 required staff assistance with mobility in her wheelchair and required assistance of one staff member with a sit to stand transfer aid for transfers. In addition, the Care Plan documented Resident #12 as a risk for falls related to previous neck trauma. A. The November 2025 Treatment Administration Record (TAR) included a Physician order dated 7/23/25 for a heating pack to abdomen for 20 minutes one time a day for abdominal discomfort. The order reflected hold dates from 11/21/25 to 11/26/25 and then discontinued on 11/26/25. Review of the November TAR revealed Staff D, Registered Nurse (RN), signed off the heating pack on the evening of 11/20/25 indicating Resident #12 received the heating pack. An Incident Report (IR) title New Skin Issue dated 11/21/25 at 9:20 AM documented Staff C, Licensed Practical Nurse (LPN), went into Resident #12 bathroom, where she sat on the toilet, to reinforce her colostomy appliance, when she noticed a large blister on the lower left quadrant of her abdomen. Resident #12 said it didn't hurt and she didn't know she had a blister there. Resident #12 stated she received a hot pack yesterday afternoon on the same spot and suspected it was from that. When asked who gave her the hot pack, Resident #12 refused to discuss. The facility education form dated 11/25/25 documented Staff D received education on heating devices. The form instructed the nurse could only apply the heating devices and they could only use the heating devices provided from the facility. Residents should not use heating devices from outside the facility and they must have an order obtained for any heating device used. In addition, there should be a barrier over the heating device when applied. The Skin and Wound form dated 11/21/25 revealed a blister to the left lower abdomen that measured 5.2 centimeters (cm) (length) x 2.2 cm (width). The Progress Note dated 11/21/25 at 11:55 AM documented the on-call Physician ordered to hold the hot pack and monitor the blister, leave uncovered and call back to get treatment orders when ruptured. The Progress Note dated 11/26/25 at 2:49 PM documented Resident #12 received education about using a protective covering with her heat packs. Resident #12 verbalized understanding. The Skin and Wound form dated 12/2/25 revealed the blister to the left lower abdomen<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | deteriorated and measured 3.7 cm (length) and 2.6 cm (width). The form lacked documentation of wound characteristics. The wound image revealed the wound bed with 50% dark brown eschar (nonviable tissue) and surrounding skin red in color.The facility fax form dated 12/2/26 revealed Resident #12 blister popped and measured 3-inches. The Physician ordered antibiotic ointment and to cover with nonadherent dressing. The December 2025 TAR listed a Physician order dated 12/3/26 to apply triple antibiotic ointment to the ruptured blister on Resident #12's abdomen and cover with non-adherent dressing one time a day for a ruptured blister.An Outside Provider form titled Wound Treatment Plan dated for 12/27/26 documented they saw Resident #12 to assess the area of concern to the abdomen. Resident #12 used a microwave heating pad and developed a serous blister to the site that ruptured. The skin inspection documented a 2nd degree thermal burn to the left side of the abdomen that measured 3.0 cm x 2.5 cm x 0.1 cm with 100% biofilm (a community of microorganisms, such as bacteria, fungi, or algae, that attach to surfaces and become embedded within a self-produced extracellular polymeric substance (EPS) matrix. This matrix provides protection against external threats, such as antibiotics and the host's immune system, and allows the microorganisms to thrive in a structured community, often described metaphorically as cities for microbes.) with small amount of serous drainage (thin, watery, clear to yellow fluid). New orders received to discontinue current treatment and start the following: cleanse wound with normal saline, apply Santyl (prescription medication used for the debridement (removal) of dead tissue) to wound bed, cover with xeroform gauze (petrolatum impregnated gauze), cover with a border gauze, change daily and as needed. An Outside Provider form titled Wound Treatment Plan dated for 12/31/25 documented skin inspection of the 2nd degree thermal burn on the left side of abdomen measured 2.2 cm x 1.2 cm x 0.1 cm with improving tissue, 100% red granulation (new, vascular connective tissue during the healing process) with small amount of thin serous drainage. The wound treatment plan instructed to continue with current treatment orders. An Outside Provider form titled Wound Treatment Plan dated for 1/14/26 documented the 2nd degree thermal burn to the left side of the abdomen as healed. New order received to discontinue the current treatment. On 3/3/26 at 11:04 AM, Staff D reported Resident #12 had on her treatment plan to have a hot pack on her abdomen. She said sometimes Resident #12 would want it and sometimes she did not. She said on the night of 11/20/25, she changed Resident #12's colostomy bag around 10 PM. She said there was no redness or blisters on her abdomen at that time. She said she did not give her a hot pack that night. She said she was in the wrong for marking on the TAR that she had given one to her. She said a Certified Nursing Assistant (CNA) could have given her a hot pack after she had changed the colostomy bag. She said the facility had small hot packs that were chemical packets that you squeeze to get warm. She said usually the staff would wrap the hot pack in a towel. She said there have been a couple of times, Resident #12 asked for it not to be wrapped or she would unwrap it herself. She said the CNAs would take Resident #12 a hot pack when she asked for it. On 3/3/26 at 11:49 AM, Staff C reported Resident #12 had a big bubble on her abdomen. She said it was quite large, bigger than a quarter and was in a bad spot on her waist band. She said Resident #12 did not know she had a blister there until she went to the bathroom and she didn't voice any pain. She said Resident #12 reported she had a hot pack the evening prior on 3-11 shift and the staff identified the blister that morning. On 3/3/25 at 11:20 AM, Staff B, MDS Coordinator, and the Assistant Director of Nursing (ADON) reported Resident #12 ordered items from Amazon and other outside stores. She said Resident #12 ordered her own beaded/microwavable hot pack and had a staff member warm it up for her. She said Resident #12 did not use the hot pack the facility supplied. The ADON reported Resident #12 would not say who warmed up the hot pack for her. The ADON reported they removed the beaded hot pack from Resident #12's room when they identified the blister. She said outside hot packs are not allowed. She said the facility did not have a policy or protocol for hot packs. On 3/3/26 at 1:20 PM, Resident #12 said she didn't know for sure what caused the blister on her abdomen but guessed it was from the heating pack. She said she ordered her own microwavable heating pack from Amazon. She said a CNA heated the pack up for her. She reported<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | she did not remember the CNA. She said they had the heating pack wrapped up in a towel. She reported Staff B had the heating pack. She said she made arrangements with the previous Director of Nursing (DON) not to use it again. She said she used her own heating pack a couple of times. B. An IR titled Witnessed Fall dated 1/3/26 at 5:30 AM prepared by the previous DON documented Staff E, RN, reported he heard Resident #12 yelling for help. When he came in the room, Resident #12 had her torso on the bed and her bottom off the bed. Staff E reported he intercepted Resident #12 and helped her slide back into bed. Staff E reported Resident #12 tried to go to the bathroom and transferred herself. The IR indicated the facility notified the Physician of the intercepted fall on 1/6/26 and the responsible party on 1/7/26. Review of the Clinical Record lacked documentation of the fall, follow up fall assessments, vital signs, and a fall intervention. The Progress Note on 1/6/26 at 2:25 PM documented Resident #12 complained of left foot pain. The facility notified the Physician was notified and received a new order for an x-ray. They scheduled the x-ray for 1/7/26 due to pain and impaired mobility. The progress note lacked documentation regarding an assessment of the foot. The X-ray report dated 1/7/26 documented the following impression:i. No acute osseous findings. ii. Mild degenerative changes in the interphalangeal jointsiii. Small plantar calcaneal spurThe Progress Note dated 1/8/26 documented x-ray results printed and faxed to the Physician for review. The Clinic Visit Information and Order Sheet dated 1/29/26 documented Resident #12 went to a Physician appointment and complained of foot pain. The order sheet documented they completed a foot x-ray and gave a new order for a referral to Podiatry. The Clinic Visit Information and Order sheet dated 2/4/26 documented Resident #12 went to Podiatry due to a left foot injury. The summary documented the Physician suspected a tendon rupture or tear and would get an MRI (magnetic resonance imaging) to evaluate. They gave new orders for Resident #12 to wear an ace wrap or compression sock on the left foot. The form documented the MRI scheduled for 2/10/26 at 3:00 PM. Resident #12's February 2026 TAR included a Physician order for ace wrap or compression stock to the left foot one time a day until 2/11/26. Staff B, MDS Coordinator, obtained the MRI results on 3/3/26 at 1:13 PM. The MRI documented a comparison x-ray of the left foot on 1/29/26. The impression of the MRI showed the following:i. Mild partial-thickness partial width tear of the distal Achilles involving the deep fibers at the calcaneal insertion. ii. Old full-thickness tear of the anterior talofibular ligament.iii. Moderate full thickness cartilage loss of the posterior tibiotalar joint.iv. Unremarkable peroneal tendons without tear or subluxation. Electronic conversations between Resident #12 and the Podiatrist dated 2/10/26 and 2/11/26 revealed the results of the MRI showed some mild partial tearing of the Achilles tendon. The Podiatrist documented icing, elevation and compression were very important. The Podiatrist documented if Resident #12's swelling improved; she did not have to wear the ace wrap. He said rest and ice would help her overall pain. The Clinical Record lacked documentation Resident #12 went to the MRI on 2/10/26 and lacked follow up or communication with the Physician regarding the MRI results and lacked documentation of any new assessments/interventions related to the partial tear in the Achilles tendon. On 3/4/26 at 7:45 AM, Resident #12 reported when the nurse got her off the floor, she heard a pop in her left foot. She said a couple weeks later her foot still bothered her so she had an MRI completed. She reported the doctor did not think it was necessary to wear the ace wrap all the time. She said the discomfort in her left foot had improved. On 3/4/26 at 10:45 AM, Staff B acknowledged the facility failed to obtain the MRI results. She said Resident #12 made her own appointments and got her own results. She said Resident #12 usually told them if something needed done. On 3/4/26 at 12:34 PM, Staff B reported on 1/3/26 Resident #12 had an intercepted. She said the previous DON had to call Staff E to get information to complete the incident report. She said the previous DON provided education to the nurse regarding what was considered to be a fall. She said she thought the intercepted fall happened on a Saturday. She said the x-ray happened the following week and she would obtain the x-ray results.On 3/4/26 at 2:00 PM, the Administrator reported she expected the nurse to document a fall in the medical record. In addition, she expected the staff to follow up on the diagnostic results, communicate with the Physician, and document the<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | results/notifications in the medical records.On 3/4/26 at 4:05 PM, the Administrator reported she did not have a policy regarding Physician notification/communication.On 3/4/26 at 6:46 PM, the Administrator verified Resident #12 fell on the night of 1/3/26. She reported the nurse who assisted Resident #12 during the incident did not consider the event a fall as the resident was still halfway in her bed and he simply assisted her back into the bed. The Administrator reported Administration found out about the incident the following week on Tuesday when Resident #12 brought up that her foot was sore. The Administrator reported she believed on 1/6/26 when they notified the Physician and notified the family on 1/7/25.In addition, the Administrator reported the facility did not have a specific supervision policy regarding falls.On 3/5/26 at 8:30 AM, Resident #12 verified the nurse who picked her up off the floor was Staff E when she heard the pop in her left foot.The facility policy titled Falls reviewed 2/3/26 documented the purpose of the policy as to ensure an environment that decreases the risk of residents falls while promoting resident independence. The policy documented defined a fall as any unintentional loss of elevation in any plane. The policy directed staff to document the fall in risk management on the electronic health record and follow prompted assessment as necessary. In addition, the policy directed staff to initiate 72-hour documentation. 2. The Minimum Data Set (MDS) assessment for Resident #50 dated 12/31/25 identified a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS identified Resident #50 required substantial/maximal assistance with bed mobility, ambulation. The MDS listed Resident #50 as dependent on staff for all transfers. The MDS included diagnoses of hypertension (high blood pressure), history of traumatic brain injury, and mood disorder. The MDS documented Resident #50 had one fall with no injury since last assessment. The Care Plan initiated 6/29/23 documented Resident #50 as a risk for falls related to gait/balance problems and weakness of the lower extremities. The Care Plan directed staff to provide assistance of one with 4WW (four wheeled walker) with transfers and ambulation. The Care Plan directed staff to use a gait belt according to facility policy. An IR titled Witness Fall dated 2/11/26 at 10:40 AM documented the Certified Nurse Aide (CNA) summoned the nurse to the room and observed Resident #50 on the floor in the bathroom lying on her left side with her knee bent facing the bathroom door. Her walker sat on the outside of the bathroom with a wheelchair beside it. Resident #50 reported she lost her balance. The IR listed the Intervention as a transfer audit. A Hand Written Statement dated 2/11/26 signed by Staff F, CNA, revealed Staff F assisted Resident #50 off the toilet and he thought he was walking Resident #50 to the wheelchair but Resident #50 wanted to go to the recliner. Staff F tried to move the wheelchair while still having a hold of the gait belt but couldn't. Staff F briefly let go of the gait belt to move the wheelchair and at that time Resident #50 fell backwards. On 3/4/26 at 8:58 AM, Staff G, RN reported she went into Resident #50's room and Staff F was in the room. She said as Staff F walked Resident #50 out of the bathroom and her wheelchair was in the way. She said as Staff F went to move the wheelchair, Resident #50 lost her balance and fell. She said there were no injuries. She said the fall was witnessed and Resident #50 did not hit her head. She said they implemented the intervention to complete transfer audits with Staff F to make sure surroundings were clear before walking. On 3/4/26 at 9:14 AM, Staff F reported he helped Resident #50 off the toilet. He said he did not know who put her on the toilet. He said she had her wheelchair already set up and he thought that was where she was going. He said he was helping her walk to the wheelchair and Resident #50 decided she wanted to go to the recliner. He said he tried to move the wheelchair without letting go of Resident #50, but he could not. He said he let go of Resident #50 for a few seconds to move the wheelchair and she fell backwards. He said if he would have known she wasn't going to go to the wheelchair he would have moved it. He said he was using a gait belt. He said Resident #50 did not get hurt. Staff F said he knew Resident #50 needed the assistance of one and he should not have let go of her. On 3/4/26 at 2:00 PM, the Administrator reported she expected the staff to call for help or walk to a safe place and not take their hands off the gait belt. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to notify the Long-Term Care Ombudsman of discharge and/or transfer of residents as required for 3 of 3 residents reviewed (Residents #108, #10 and #106). The facility reported a census of 102 residents.Findings include:1. Resident #108's Minimum Data Set (MDS) assessment dated [DATE] indicated they discharged without a anticipate return on 1/20/26.Resident #108's clinical census listed a discharge on [DATE]. The clinical record lacked documentation of notification to the Long-Term Care (LTC) Ombudsman of Resident #108's discharge from the facility in January 2026 as required by federal regulation. 2. Review of the facility EHR for clinical MDS tracking revealed Resident #10 discharged from the facility on 12/27/25 with a return anticipated.Resident #10's Clinical Census reviewed 3/4/26 listed Resident #10 discharged on 12/27/25 from 12/29/25 under an unpaid hospital leave. The clinical record lacked documentation of notification to the LTC Ombudsman of Resident #10's discharge and transfer from the facility in December of 2025. 3. Review of the facility EHR for clinical MDS tracking on 3/4/26 indicated Resident #106 discharged from the facility on 1/3/26 with a return anticipated.Resident #106's Clinical Census reviewed 3/4/26 reflected they had a hospital paid leave status from 1/3/26 until 1/7/26 and 1/13/26. On 1/14/26, Resident #106 discharged from the facility. The clinical record lacked documentation of notification to the LTC Ombudsman of Resident #106's discharge and transfer from the facility in January of 2026 on the 2 occasions. During an interview on 3/4/26 at 8:45 AM, Staff H, Support Services, stated she sends the Ombudsman notification list monthly to the LTC Ombudsman, she prints the list from the facility's computer software program. Staff H acknowledged the list sent to the Ombudsman in December of 2025 and January of 2026 for discharges and transfers didn't include Residents #108, #10, and #106. During an interview on 3/4/26 at 8:55 AM, the Administrator acknowledge the notification list sent to the LTC Ombudsman in December of 2025 and in January of 2026 related to the resident's discharges and transfers didn't include Residents #108, #10, and #106. The Administrator stated they expected the Ombudsman notification report to include all discharges and transfers and sent to the LTC Ombudsman. The Administrator stated the facility didn't have a policy on notification to the LTC Ombudsman. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to provide care and services according to accepted standards of clinical practice for 1 of 1 resident reviewed (Residents #102) for a medication error. Resident #102 received medications that were not prescribed to him. The medications were prescribed to Resident #63 who lived across the hallway. The facility reported a census of 102 residents.Findings include: Resident #102's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMs) score of 07, indicating moderately impaired cognition. The MDS identified Resident #102 required partial/moderate assistance with transfers. The MDS included diagnoses of anemia, hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), and cerebral infarction (stroke). An Incident Report (IR) titled Medication Error dated 1/11/26 at 8:20 PM, documented Staff A, Registered Nurse (RN) was passing medications to multiple residents. The IR documented Staff A sat another resident medication behind Resident #102's television. Staff A had Resident #102's medication in hand and reached to grab the water pitcher from the nightstand. Resident #102 quickly grabbed the other resident's medications and put them in his mouth. Staff A had Resident #102 spit out the medications back into the medication cup. Resident #102 was able to spit out all the medications except for two pills which were assumed that he had swallowed. Resident #102's mouth was rinsed out with water, and he was unable to spit up any more medications. Staff A called on the call provider with no new orders. The IR report documented the two medications Resident #102 swallowed were carbidopa/levodopa extended release (ER) 25-100 mg (milligrams) (used to treat the symptoms of Parkinson's disease) and melatonin 5 mg tablet (non-habit-forming sleep aid). The facility form titled Verbal Coaching completed by the Director of Nursing (DON) on 1/15/26 documented she contacted Staff A on 1/12/26 via text and a phone call to explain why coaching was needed and the expectation of supervision at all times with medications. On 3/4/26 at 2:39 PM, Staff A reported on the evening of 1/11/26 she was running around trying to get the medications passed. She said she prepared 2 resident medications at the same time (Resident #102 and Resident #63). She said Resident #63 lived across the hallway from Resident #102. She said she was going to run in and give Resident #102 his medications and then go to Resident #63's room. She said it was not common for her to prepare 2 resident's medications at the same time. She said she was running behind. She said it was not something she liked to do and was trying to give the medications as close to on time as possible. She said she entered Resident #102's room with 2 medication cups. She said she sat Resident #63's medication cup behind Resident #102's TV. She said she did not think Resident #102 saw the medication cup or knew about it. She said as she went to reach for Resident #102's water pitcher, she saw him stand up and grabbed Resident #63's medications and put them in his mouth. She said she had Resident #102 spit the medications out right away. She said she didn't remember which medications Resident #102 swallowed but thought one was melatonin. She said she called the on-call provider and told him what had happened. She said the Physician did not voice any concerns or give any new orders. She said about a week later the DON texted her and said she was going to have to write up a verbal coaching regarding visualizing medications at all times. She said she did not see the verbal coaching and did not sign anything. On 3/4/27 at 4:30 PM, Staff B, MDS Coordinator, said she expected staff to prepare and pass medication to one person at a time and have eyesight on the medications.The facility policy titled Process: Medication Administration reviewed 10/15/25 documented accepted professional standards for drug administration included: right drug, right patient, right time, right dose, and right route. The facility policy titled Process: Medication Error reviewed 10/9/25 documented the purpose of the policy was to ensure quality assurance, to ensure that residents are receiving the medications as prescribed by a medical provider. The policy directed that all medications would be administered following the right of medication management. The 5<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | rights of Medication Management include the right medication, right dose, right resident, right route and right time. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interviews and policy review, the facility failed to change tubing hooked to a nebulizer (medical device that converts liquid medication into a fine mist to treat respiratory conditions) for 1 of 1 residents reviewed (Resident #12). The facility reported a census of 102 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #12 dated 1/14/26 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS included diagnoses of moderate persistent asthma and COPD (chronic obstructive pulmonary disease) (a progressive, incurable lung disease that restricts airflow). The Care Plan initiated on 10/7/23 revealed Resident #12 has asthma related to COPD and used scheduled and as needed nebulizer and inhalers. The care plan directed staff to clean the nebulizer every night per facility cleaning protocol but did not address how often to change the nebulizer tubing and mask. The following Physician Orders pertain to nebulizer treatments for Resident #12:-Written on 11/26/25- Budesonide Inhalation (a steroid used for maintenance treatment of asthma) 0.5 mg(milligrams)/2 ml (milliliters) 1 vial BID (twice a day) for COPD.-Written on 11/26/25- Preformist Inhalation (used to control COPD symptoms) nebulization Solution 20 mcg/ml 1 vial orally via nebulizer BID for COPD.-Written on 11/26/25- Albuterol Sulfate Inhalation Nebulization solution 0/084% 1 vial inhale every 4 hours as needed for wheezing. On 3/2/26 at 2:16 PM, observed nebulizer tubing dated 12/17/25 attached to Resident #12's nebulizer machine.On 3/3/26 at 1:20 PM, witnessed nebulizer tubing dated for 12/17/25 attached to Resident #12's nebulizer machine. Directions for changing the nebulizer mask or tubing could not be located in the Physician orders or on the TAR (Treatment Administration Record). On 3/3/27 at 3:01 PM, the Assistant Director of Nursing (ADON) acknowledged no one changed the nebulizer tubing and mask since 12/17/25. She reported she expected the staff to change the nebulizer tubing and mask every two weeks. She said the clinical coordinator was responsible for changing the mask and tubing. On 3/4/26 at 9:56 AM, the Administrator reported they completed an audit on the residents that used nebulizers and identified the facility had a gap. The Administrator reported they changed all tubing out as of yesterday (3/3) and a put a process in place.The facility policy titled Nebulizer Disinfecting/Cleaning Process approved on 3/3/26 directed staff to change the nebulizer mask and tubing every 2 weeks and mark the tubing with an orange sticker with the date the tubing was changed, time it was changed and who it was changed by. In addition, the nebulizer mask to be dated with a permanent marker. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165424 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethany Life | 212 Lafayette Street<br>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.

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|---|---|
| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.<br><br>Based on clinical record review, and staff interviews, the facility failed to notify the Primary Care Physician of a fall in a timely manner, failed to follow up and obtain MRI (magnetic resonance imaging) results and communicate with the Physician who ordered the MRI for further orders/direction for 1 of 21 residents (Resident #12) reviewed. The facility reported a census of 102 residents. Findings include: The Minimum Data Set (MDS) assessment for Resident #12 dated 10/22/25 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS identified Resident #12 required substantial/maximal assistance with bed mobility and was dependent on staff for all transfers. The MDS documented ambulation did not occur. The MDS included diagnoses of moderate persistent asthma, COPD (chronic obstructive pulmonary disease) (a progressive, incurable lung disease that restricts airflow), spinal enthesopathy of thoracic and cervical region (painful condition involving inflammation or degeneration), congestive heart failure (heart cannot pump blood efficiently causing fluid buildup), major depressive disorder and anxiety.An Incident Report (IR) titled Witnessed Fall dated 1/3/26 at 5:30 AM prepared by the previous Director of Nursing (DON) documented Staff E, Registered Nurse (RN), reported he heard Resident #12 yelling for help. When he came in the room, Resident #12 had her torso on the bed and her bottom off the bed. Staff E reported he intercepted Resident #12 and helped slide her back into bed. Staff E reported Resident #12 tried to go to the bathroom and was transferring herself. The IR indicated the facility notified the Physician of the intercepted fall on 1/6/26, 3 days after the incident. The Clinic Visit Information and Order sheet dated 2/4/26 documented Resident #12 went to Podiatry due to a left foot injury. The summary documented the Physician suspected a tendon rupture or tear and would get an MRI (magnetic resonance imaging) to evaluate. The form documented Resident #12 had an MRI scheduled for 2/10/26 at 3 PM. Staff B, MDS Coordinator, obtained the MRI results on 3/3/26 at 1:13 PM.The impression of the MRI showed the following:Mild partial-thickness partial width tear of the distal Achilles involving the deep fibers at the calcaneal insertion. Old full-thickness tear of the anterior talofibular ligament.Moderate full thickness cartilage loss of the posterior tibiotalar joint.Unremarkable peroneal tendons without tear or subluxation.The Clinical Record lacked documentation Resident #12 went to the MRI on 2/10/26 and lacked follow up or communication with the Physician regarding the MRI results. On 3/4/26 at 10:45 AM, Staff B acknowledged the facility failed to obtain the MRI results. She said Resident #12 made her own appointments and got her own results. She said Resident #12 usually told them if something needed done.On 3/4/26 at 6:46 PM, the Administrator verified Resident #12 fell on the night of 1/3/26. She reported the nurse who assisted Resident #12 during the incident did not consider the event a fall as the resident was still halfway in her bed and he simply assisted her back into the bed. The Administrator reported Administration found out about the incident the week before on Tuesday when Resident #12 brought up that her foot was sore. The Administrator reported she believed this was on 1/6/26 when the notified the Physician. On 3/4/26 at 4:05 PM, the Administrator reported she did not have a policy regarding Physician notification/communication. |

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|---|---|---|---|
| | 165424 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethany Life | 212 Lafayette Street<br>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.

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>Based on review of the facility's Quality Assurance Performance Improvement (QAPI) plan, the facility's surveys within the last year, and staff interview, the facility failed to correct their own deficiencies for 1 of 1 area of concern. The facility reported a census of 102 residents. Findings include:The facility had the following concern identified at the current recertification survey that had been cited during a complaint survey in November of 2025 and during a complaint survey in December of 2025:Medication ErrorThe facility's Quality Assurance and Performance Improvement (QAPI) policy, dated 10/15/25, documented it is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. The QAA Committee shall be interdisciplinary and shall develop and implement appropriate plans of action to correct identified quality deficiencies. The QAPI plan will address the following elements:Design and scope of the facility's QAPI program and QAA Committee responsibilities and actions.Policies and procedures for feedback, data collection systems, and monitoring.Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following:Tracking and measuring performance.Establishing goals and thresholds for performance improvements.Identifying and prioritizing quality deficiencies.Systematically analyzing underlying causes of systemic quality deficiencies.Developing and implementing corrective action or performance improvement activities. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.During an interview on 3/5/26 at 9:56 AM, the Director of Nursing (DON), stated the facility worked on medication errors and addressed it in their QAPI meetings. The DON stated the facility had more work to do in regard to medication errors and acknowledged the facility had repeat concerns with medication errors in prior complaints completed in November 2025, December of 2025, and on the current survey. |