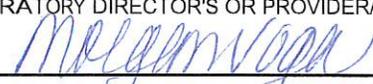


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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165424 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/22/2025 |
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| NAME OF PROVIDER OR SUPPLIER Bethany Life | STREET ADDRESS, CITY, STATE, ZIP CODE 212 Lafayette Street , Story City, Iowa, 50248 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F0000  | <p>INITIAL COMMENTS</p> <p>Correction date: <u>12/31/25</u></p> <p>The following deficiency resulted from investigation of complaints #2677953-C and #2689409-C, conducted December 18, 2025 -December 22, 2025.</p> <p>Complaint #2677953-C resulted in a deficiency.</p> <p>See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.</p> | F0000 | <p>Elements detailing how you will correct the deficiency as it relates to the individuals:</p> <p>Resident #1 was discharged on 4/18/1925.</p> <p>How you will act to protect residents in similar situations:</p> <p>Education regarding Medication Administration provided to nursing staff on 12/22/25.</p> | |
| F0760 SS = D | <p>Residents are Free of Significant Med Errors</p> <p>CFR(s): 483.45(f)(2)</p> <p>The facility must ensure that its-</p> <p>§483.45(f)(2) Residents are free of any significant medication errors.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on clinical record review, facility policy, and staff interview, the facility failed to follow physicians order for medication administration for which caused a resident not to receive their diuretic medication (medication to remove salt and water from your body) for 1 out of 4 residents. (Resident #1). The facility identified a census of 115 residents.</p> <p>Findings include:</p> <p>Resident #1's Minimum Data Set (MDS) assessment dated 3/30/25, documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. Resident #1 could understand and understood others with no behavior or mood issues. Resident #1 required supervision to partial assistance with all aspects of activities of daily living. The MDS included diagnoses of high blood pressure, congestive heart failure (poor function heart resulting in a back of fluids in the body), renal (kidney) and respiratory (lung) failure.</p> | F0760 | <p>Include measures you will take or systems you will alter to ensure that the problem does not recur;</p> <p>DON or designee will audit triple checks to ensure that there are parameters in place if indicated/needed. Two times a week x3 weeks, then one time a week x2 weeks and then randomly.</p> <p>Admissions / Re-Admissions Leadership Audit will be completed and updated to reflect if a resident is on a diuretic. Audit tool amended on 12/30/25.</p> <p>Additional reinforcement for nursing staff will be provided at our Inservice on 1/21/26.</p> <p>How you plan to monitor performance to make sure that solutions are permanent:</p> <p>Audits will be reviewed at QAPI and on an as needed basis.</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 reverse for further 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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Administrator | (X6) DATE 12/31/25 |
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| F0760 SS = D | <p>Continued from page 1</p> <p>The Care Plan initiated date 3/27/25, indicated Resident #1 had a self-care performance deficit related to weakness from a recent hospitalization and congestive heart failure. The Care Plan directed Resident #1 required daily weights, Tubi-grips on every morning (AM) and off every evening (PM), and administer diuretic medications as ordered by the physician.</p> <p>The Physician Discharge orders dated 3/27/25 at 11:57 AM, instructed staff to give Lasix (medication use to treat fluid retention) 20 milligrams, 1 tablet (20 mg total) by mouth daily as needed (PRN) if weight increased 3 pounds from baseline.</p> <p>The Admission/Readmission Assessment dated 3/27/25 at 6:24 PM, documented a weight of 108.6 pounds at 3:21 PM.</p> <p>Resident #1's March 2025 Medication Administration Record (MAR) instructed staff to administer Lasix oral tablet 20 mg 1 tablet by mouth every 24 hours PRN for increase in weight gain 3 pounds from baseline. The MAR, documented Resident #1 weight on the following dates:3/30/25 = 111 pounds, no Lasix givenResident #1's April 2025's MAR instructed staff to administer Lasix oral tablet 20 mg, give 1 table by mouth every 24 hours as needed for increase in weight gain 3 pounds from baseline. The MAR documented Resident #1 weight on the following dates:4/3/25=112.8 pounds, no Lasix given4/4/25=111.4 pounds, no Lasix given 4/11/25=112.6 pounds, no Lasix givenThe undated Encounter for Adult Medicine dated 3/31/25 documented no edema in the right and left lower leg, with skin warm and dry.</p> <p>The Encounter for Adult Medicine dated 4/7/25 documented daughter requested Resident #1's Lasix to be restarted at their previous dose of 4 times a week. Resident #1 discontinued Lasix given as needed for weight gain of greater than 3 pounds per day. Review of weight showed Resident #1 consistently held around 111 pounds which is up from admission weight of 108 pounds. Patient did report her legs are more swollen than at their baseline. Her right and left lower leg show 3 plus edema present, with skin warm, dry, and erythema (redness of the skin caused by increased blood flow to the surface) to bilateral (both) lower extremities. Due to the edema and borderline weight gain, the provider ordered to schedule a trial Lasix twice a week with the as needed doses.</p> <p>The Clinic Visit and Information and Order Sheet dated 4/15/25 at 11:30 AM, listed orders to give a total of 40 mg Lasix on 4/15/25 and 4/18/25,. In addition, give 20 mg Lasix on 4/16/25, 4/17/25, 4/19/25, and 4/20/25.</p> | F0760 | | |

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| F0760 SS = D | <p>Continued from page 2</p> <p>The Encounter for Adult Medicine dated 4/18/25 documented the primary care provider (PCP) saw Resident #1 on 4/15/25 for an evaluation of edema. The PCP increased the scheduled Lasix to 40 mg twice a week with 20 mg the other days. On 4/15/25 Resident #1 weighed 114 pounds and on 4/16/25 weighed 113 pounds and on 4/17/25 weighed 113 pounds. That day Resident #1 weighed 113.6 pounds. Resident #1's left and right lower leg showed 3 plus edema with skin warm and dry and erythema present on bilateral lower legs.</p> <p>Interview on 12/22/25 at 1:30 PM, the Director of Nursing verified they expected the nurses are to follow the physicians' orders as written. In reviewing Resident #1's clinical record, the facility failed to give the Lasix as needed when Resident #1's weight increased by 3 pounds from the baseline upon admit.</p> <p>The Process: Medication Administration policy dated 10/15/25, instructed the purpose of a physician order includes dosage, route, frequency, duration or other required considerations is required for administration of medication. Access to knowledge regarding classification, action, correct dosage, side effects of a medication and manufactures specifications is required prior to administration by qualified personnel. Specific directions prior to administration of medication will be completed.</p> | F0760 | | |