Printed: 04/08/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165424	A. Building B. Wing	01/15/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, nursing competency, resident and staff interviews, the facility failed to ensure documentation reflected a resident left the facility unattended and returned with staff for 1 of 3 residents reviewed (Resident #1). The facility identified a census of 112 residents.Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. Resident #1 could understand and be understood by others. They had no documented behaviors, no wandering issues or rejecting of cares. The MDS listed Resident #1 as independent with personal hygiene and ambulation with a 4 wheeled walker. The MDS included diagnoses of hypertension (high blood pressure), Alzheimer's, non-Alzheimer's dementia, cataracts (a clouding of your eyes making vision blurry, hazy or less colorful), glaucoma (eye disease that damages the optic nerve, leading to irreversible vision loss and potential blindness) and macular degeneration (damages of the eyes center causing blurred or loss of sight, and difficult reading).The Care Plan Focus initiated 10/1/25, indicated Resident #1 had an elopement risk/wanderer related to impaired safety awareness, wears a wander alert pendent, and independent with mobility with use of 4 wheeled walker.On 1/13/26 at 4:15 PM, observed Resident #1 sitting in a recliner in his room, attempting, unsuccessfully, to use a cellphone. Resident #1 couldn't recall or remember going outside or being moved to another household.The undated Wanderguard List of residents, documented Resident #1 resided in Life Bridges household.The Resident List Report dated 1/13/26 at 3:30 PM, documented Resident #1 resided in [NAME] Place household.On 1/14/26 at 12:20 PM, the facility's Director Of Nursing (DON) and Assistant Director of Nursing (ADON), explained Resident #1 lived in Life Bridges household and went out the north door of the facility while supervised when outside. Due to the incident, the facility decided to transfer Resident #1 to a locked unit in another household. The DON, stated since Resident #1 didn't actually elope, they decided that it was not necessary to document the incident in the clinical record. On 1/14/26 at 1:15 PM, the DON verified that looking back at the situation now, staff are expected to document in the clinical record any incidents or unusual occurrence that happen with all residents. They train the staff with the Nurse Competency Check-off list upon hire, which included documentation.The Nurse Competency Check Off List reviewed 6/24/24, explained that all skills must be initialed by the Trainee and Trainer, including documentation of follow-up notes, family communication, hot charting, changes in condition, behaviors, new skin issues, unusual events, and alleged abuse.

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