STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165017	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Cedar Rapids	1940 First Avenue NE Cedar Rapids, IA 52402

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 41537 Based on record review, staff interviews, and policy review the facility failed to ensure medication carts were locked at all times when not in use. The facility also failed to ensure resident medical records on the Electronic Health Record (EHR) were not left open and unattended for others to view. The facility also failed to provide professional standards of practice during medication administration when 1 of 2 nurses observed for medication administration failed to stay with a resident (Resident #21) and ensure nine (9) medication pills were taken (swallowed). The facility reported a census of 62 residents. Findings include: 1. During a continuous observation on 3/25/2024 of Legacy Hall (a wing of the facility) medication cart revealed the following: 3:16 PM the Legacy medication cart was unlocked without staff present and the right third (3rd) drawer was open approximately two (2) inches. 3:20 PM Resident #33 rolled out into the hallway and was observed sitting in the doorway of his room in his wheelchair, next to the medication cart, he was close enough to be able to open drawers. 3:24 PM Resident #33 wheeled past the cart and was out of reach from opening it. 3:31 PM Staff G, Registered Nurse (RN) locked the medication cart. 48886 2. During an observation on 3/27/24 at 7:29 AM, Staff H, Registered Nurse (RN), left resident medication administration EHR open and unattended for approximately eight (8) minutes. During an observation on 3/27/24 at 7:45 AM, Staff H left resident medication administration EHR open and unattended for approximately four (4) minutes. During the same observation, Staff H left nine (9) oral medications in Resident #21's room and did not observe him take the medications, leaving the room prior to the resident taking his medication. (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EHR, Medication Administration Record, for Resident #21 revealed the resident was prescribed nine (9) medications to be taken orally everyday in the morning. During an interview on 3/27/24 at 8:07 AM, Staff H advised she would normally close resident EHR, but forgot to do that a few times this morning. Staff H acknowledged an expectation to close the screen or lock it. Staff H further acknowledged she would expect to watch the resident take their medications. During an interview on 3/28/24 at 9:00 AM, the Director of Nursing (DON) revealed her expectation of nursing staff is to ensure resident EHR would not be left open to view when not in use. The DON further informed she would expect the medication cart be locked at all times when staff step away from the medication cart, and she would also expect staff to stay with a resident until the resident had taken their medication. Review of facility policy Medication Administration - Medication Pass, with a revision date of 5/2023, documented under the procedure section of the policy to provide privacy and to remain with patient until the administration of the medication is complete, as well as to secure the cart as required, to lock the medication cart when not in direct view of the nurse administering medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, policy review, and staff interview, the facility failed to provide and document the implementation of non-pharmacological interventions (any type of healthcare intervention which is not primarily based on medication. Some examples include exercise, diversion activity, snacks, toileting, naps, music, etcetera) prior to administration of as needed anti-anxiety medications for 1 of 5 residents sampled (Resident #43). The facility identified a census of 62 residents. Findings include: Resident #43's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status Score of 9/15 indicating moderate cognitive loss. The MDS documented Resident #43 received anti-anxiety medications for an anxiety disorder. The Care Plan dated 3/12/24 documented Resident #43 utilized anti-anxiety medications and directed the staff to monitor for increased risk of confusion, amnesia (memory loss), loss of balance, cognitive impairment that looks like dementia, and monitor as needed for safety. The Care Plan lacked revision to include non-pharmacological interventions to address agitation or restlessness prior to administration of as needed anti-anxiety medication. A 3/26/24 review of Resident #43's physician orders revealed the following orders: a. Clonazepam oral tablet 0.5 milligrams (mg), give 0.5 mg orally every 8 hours as needed for anxiety for 14 days. Start date 2/23/24. b. Clonazepam oral tablet 0.5 milligrams (mg), give 0.5 mg orally every 8 hours as needed for anxiety for 14 days. Start date 3/10/24. c. Clonazepam oral tablet 0.5 milligrams (mg), give 0.5 mg orally every 8 hours as needed for anxiety for 14 days. Start date 3/26/24. A 3/26/24 review of the February 2024 Medication Administration Record (MAR) documented the facility administered the medication at the following dates/times: a. 2/25/24 at 6:42 AM b. 2/26/24 at 7:16 AM and 7:10 PM c. 2/27/24 at 5:03 PM d. 2/28/24 at 2:07 AM e. 2/29/24 at 7:40 AM (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/24 at 4:4 PM Staff A Registered Nurse (RN) reported nursing interventions should be tried and documented prior to given a as needed anti-anxiety medication. Staff A explained normally the nurses document the interventions in the Progress Note that is linked with the MAR. She reported the nurses get so busy, interventions may not get documented and if it wasn't documented, it didn't get done. A 3/27/24 review of the March 2024 MAR documented the facility administered the Clonazepam as needed medication 28 times from 3/01/24 to 3/27/24. A review of the February and March 2024 Progress Notes from 2/25/24 to 3/27/24 revealed the facility only documented implementing non-pharmacological interventions prior to the administration of as needed Clonazepam medication on 3/02/24 and 3/04/24. The Progress Notes also documented the following: a. 2/29/24 at 7:40 AM Nurse assessed. b. 3/1/24 at 7:15 AM Nurse assessed. c. 3/20/24 at 8:02 AM Nurse assessed. d. 3/26/24 at 3:27 PM Nurse assessed. e. 3/27/24 at 7:56 AM Nurse assessed. None of the nurse assessment entries documented if non-pharmacological interventions had been utilized, how many non-pharmacological interventions had been utilized and the outcome of those interventions. During an interview on 3/27/24 at 9:51 AM Staff B RN verbalized the Certified Nursing Assistant's (CNA's) provide interventions for behaviors that are listed in the Care Plan and communicated over into the Kardex for the staff to see. The Kardex communicates the behavioral interventions for the staff to provide. Interventions should be tried prior to administering as needed anti-anxiety medication and those interventions should be documented in the Progress Notes which link from the MAR. On 3/27/24 at 10:10 AM Staff C CNA reported she is agency, but has come to the facility several times. She reported many times when she comes on shift she doesn't have a computer login to be able to access the resident's electronic Care Plan or Kardex, so she has to rely on asking other staff about resident behaviors and what needs to be done. She verbalized she didn't really know if the resident behaviors and interventions are included in the Care Plan or Kardex. She would just go by what other staff members tell her to do. She voiced Resident #43 didn't really have any behaviors that she was aware of. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/24 at 10:18 AM Staff D, CMA reported resident behaviors are listed in the Point of Care (POC) Kardex. She would look there to see listed behaviors and interventions to address those behaviors. She explained when you work with residents for a long time, you just know their behaviors. She documents any resident behaviors in the POC Task record. Those records go directly to the Director of Nursing (DON) and Assistant Director of Nursing (ADON) for review. She reported Resident #43 doesn't really have behaviors. She will just state she is shaky or is really cold at times, but those are not really behaviors. On 03/27/24 10:57 AM Staff E ADON explained staff should be able to go to the Care Plan to see resident behaviors and interventions should be listed in the Kardex to address those behaviors. She reported the nurse should document the situation in the Progress Notes as to what led up to the need for the anti-anxiety medication and what interventions were done prior to given the medication. All that should be documented in the resident Progress Notes 100 percent. A review of the February 2024 Documentation Survey Report V2 documented from 2/23/24 to 2/29/24 Resident #43 had no behaviors or behaviors were documented as not applicable. The Report under Behaviors and Interventions documented NB from 2/23/24 to 2/29/24 indicating Resident #43 had No Behaviors. A Review of the March 2024 Documentation Survey Report V2 from 3/01/24 to 3/27/24 revealed only one day, 3/11/24, that Resident #43 exhibited anxiety/restlessness and had documented interventions of a meaningful activity and one to one activity provided with the Resident's behavior remaining the same. All other days of the month documented the Resident did not have behaviors; behaviors were not applicable to the resident or the resident was not available. A review of Resident #43 Kardex on 3/27/24 lacked documentation of identified behaviors or interventions to address behaviors to direct staff in Resident #43's care. On 3/27/24 at 1:30 PM Staff F CMA reported she cannot give as needed medication unless approved by a nurse. She is required to inform the nurse of the resident situation, interventions that have been done, and get approval to give the as needed psychotropic medication. She reported it is the nurse's responsibility to document the situation and the interventions in the nursing Progress Notes. Staff F verbalized she can only document the administration of the as needed medication and then the nurse follows up on the response if it was effective. During an interview on 3/27/24 at 3:32 PM the DON reported there should be a nursing order to monitor resident behaviors and to provide three interventions. She reviewed Resident #43's orders and verbalized she did not see the nursing orders. She reported she expects three interventions to be tried and documented before as needed anti-anxiety medications are administered. The Behavior Management Guide revised 7/2023 provided by the facility directed non-pharmacological interventions should be attempted prior to the use of any psychoactive medication