

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Southeast Iowa Regional Medical - Klein Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 S Gear Street West Burlington, IA 52655	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47336</b></p> <p>Based on observation, interview, record review, and the facility policy, the facility failed to ensure nursing staff watched and supervised residents take their medications after issuing in a medication cup for 2 of 7 residents (Resident #7, and Resident #61) reviewed. The failure resulted in a medication being left unattended in common areas within the facility, and a resident not taking her medication for more than 20 minutes after administered. The facility reported a census of 101 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment, dated 4/17/24, revealed Resident #7 scored a 12 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated moderately impaired cognition. The MDS revealed diagnoses for non-traumatic brain dysfunction, unspecified dementia without behavioral disturbance, and depression. The MDS revealed resident took antianxiety, antidepressant, and opioid medications.</p> <p>The EMR (Electronic Medical Record) Medication Administration Record (MAR) revealed the following medications that were white pills administered on 6/12/24 at 8:21 AM:</p> <ul style="list-style-type: none"> <li>a. hydrocodone/acetaminophen 5 mg(milligrams)/325 mg- 1 tablet BID (twice daily)</li> <li>b. loratadine 10 mg- 1 tablet daily</li> <li>c. acetaminophen 500 mg- 1 tablet TID (three times a day)</li> <li>d. amiodarone 100 mg - 1 tablet daily</li> <li>e. buspirone 10 mg -1 tablet BID</li> <li>f. calcium-vitamin D (Calcium 600+D)- 1 tablet TID</li> <li>e. citalopram 40 mg -1 tablet daily</li> <li>g. potassium chloride 10 mEq (milliequivalents)-1 tablet daily</li> </ul> <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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation 6/12/24 at 8:56 AM, Staff A, Dietary Aide told Staff C, CNA that he found a pill left on the table. Staff C then informed Staff B, RN (Registered Nurse) that Staff A found the pill left on the table and handed Staff B the medication cup with a white pill in it. Staff B then went down the hall towards Resident #7 room and when Staff B returned to the common area, she no longer had the medication cup in her hand.</p> <p>During an interview on 6/12/24 at 10:30 AM, Staff A stated he found a medication cup with a white pill on the table and he gave it to the nurse. Staff A asked if he had found pills on the table before this incident and he stated it happened once or twice before when he cleared off the table and he just told the nurse about it.</p> <p>During an interview on 6/12/24 at 11:05 AM, Staff B, RN stated normally Resident #7 took her pills when she handed them to her. Staff B asked how she knew the pill was Resident #7 and she stated Resident #7 was the only resident who sat at the table where the pill had been found. Staff B stated normally she would of thrown the pill away, but she felt frazzled. Staff B stated Resident #7 not always cognitive [cognitively aware] but she did always count her pills. Staff B asked what the resident's response was when she took her the pill and she stated Resident #7 said oh, and took it. Staff B confirmed the pill in the medication cup was white.</p> <p>During an interview on 6/12/24 at 12:58 PM, Staff B stated she couldn't identify the white pill because the pharmacy sent bags with the barcode and the pill description on them and she already threw them away.</p> <p>During an interview on 6/12/24 at 1:36 PM, Resident #7 stated she took her medications at the breakfast table this morning and one was left in the cup and they brought it to her this morning. She stated the nurse usually brought her medications to her room and left them on her table. She stated sometimes the nurse watched her take her pills and other times they didn't. She stated the nurses knew she took her pills.</p> <p>During an interview on 6/12/24 at 1:55 PM, Staff C, CNA stated Staff A was clearing off the dining room tables and found a medication cup with a pill left in it. Staff C stated Staff A told her about the pill and she took it and gave it to the nurse. Staff C asked if pills left in the medication cups on the table happened often and she stated every now and then and she didn't think the nurses should leave the medications on the table. Staff C queried if that practice happened often and she stated it depended on the nurse and if the resident cognitive [cognitively aware]. Staff C stated this incident happened with Resident #7 before and she didn't know if the resident didn't tip her cup all the up.</p> <p>48888</p> <p>2. The MDS, dated [DATE], revealed Resident #61 had a BIMS score of 10 out of 15, indicative of a moderate cognitive impairment. Diagnoses included bilateral macular degeneration, depression, and anxiety disorder. Medications included an antiplatelet and antidepressant medication.</p> <p>The Care Plan, revised 05/16/24, lacked a focus area and interventions for Resident #61 to self-administer medications.</p> <p>The June 2024 MAR lacked documentation of Resident #61 self administration of medications.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/11/24 at 08:06 AM, Staff D, Licensed Practical Nurse (LPN), placed a medication cup that contained various pills and a bottle of eye drops in front of Resident #61. Medications left in front of Resident #61 as Staff D passed medications and drinks to other residents. At 08:27 AM, the medication cup, set in front of Resident #61, continued to contain various pills without direct staff supervision.</p> <p>On 06/13/24 at 08:00 AM, Staff E, Registered Nurse (RN) revealed many residents preferred to take their medications at dining room table after they eat. Staff E stated that neither facility policy or training instructed staff to leave medications with residents at dining room table but was resident preference. Staff E stated residents can refuse to take medications when given, but stated she appreciated the risk of leaving medications at the table.</p> <p>During an interview on 6/13/24 at 9:09 AM, the Interim DON (Director of Nursing) stated she would of expected the nurses to stay with the resident to make sure the medications were taken. She stated the nurse expected to stand by the resident while they take their pills.</p> <p>The Facility Medication Administration Policy dated 9/22 revealed the following information:</p> <p>a. General Considerations</p> <ol style="list-style-type: none"> <li>1. Verify that the rights of medication administration have been followed.</li> <li>2. Accurately record time administered on EHR (Electronic Health Record) medication administration record (MAR). When scheduled time must be changed, the medication is rescheduled, and the reason documented.</li> <li>3. Self-administration of drugs is permitted only with a physician's order. An assessment will be completed within the EHR.</li> </ol> <p>b. Medications may be stored:</p> <ol style="list-style-type: none"> <li>1. Elders may keep medications at bedside that have a physician's order and they had been evaluated to be safe in self-administration located in the assessment in the EHR.</li> </ol>		

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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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48374</b></p> <p>Based on observations, facility policy review, food temperatures, staff and resident interviews the facility failed to provide food at a safe temperature in 2 of the 7 households (Heritage House, and Cobblestone House) reviewed, and palatable food at a preferred temperature for 1 of 2 residents (Resident #90) in the sample. The facility reported a census of 101 residents.</p> <p>Findings Include:</p> <p>On 6/10/2024 at 11:35 AM, Food Service/Dietary Manager stated all food items are temped when they come out of the ovens and all individual household kitchens check and log all of the meal items at the point of service.</p> <p>On 6/11/2024 at 12:20 PM, upon arrival on the unit the Food Service/Dietary Manager learned Staff A, dietary staff had started to plate the noon meal. When asked, Staff A stated he had not checked the food temperatures prior to serving the noon meal. Food service was temporarily halted by the Food Service Manager and all food temperatures were checked by the staff for the steam table and the cold service food. The chicken salad was temped three times resulting in a hold temperature of 46 degrees. The mechanical soft chicken temped at 127 degrees. Staff A stated he had not had time to add more water to the steam table. Staff A also stated the chicken salad was brought upstairs to me as a special order item.</p> <p>On 6/11/2024 at 1:10 PM The Food Service Manager stated he would implement additional training for staff. He also stated this was a learning experience for his workers and they would be following procedure.</p> <p>On 6/12/2024 at approximately 3:20 PM, Staff A stated hot food should be held at 135 degrees or higher on the steam table. Cold food should not be above 41 degrees. Staff A reported he should have taken the time to check and log the noon meal temperatures.</p> <p>On 6/12/23 at approximately 4:05 PM, the Administrator stated it is her expectation that all agency policies and procedures would be followed and residents would not be served any food that was not within normal temperature limits.</p> <p>47336</p> <p>2. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #90 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. The MDS revealed the resident ate independently.</p> <p>During an interview on 6/10/24 at 9:52 AM, Resident #90 stated the food tasted bad yesterday and the vegetable were overcooked. Resident #90 stated she ate in the dining room and a lot of times the food tasted cold and not hot. She stated a lot of times the potatoes were not fully cooked and if they had something like roast beef they couldn't chew it. Resident #90 stated she was not the only resident who felt this way about the food.</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>During an observation on 6/11/24 at 12:45 PM, Resident #90 took a bite of her broccoli and made a face and turned her plate around so the chicken placed in front of her. Resident #90 finished the bite of broccoli but didn't take another bite.</p> <p>During an interview on 6/11/24 at 3:05 PM, Resident #90 stated the broccoli tasted overcooked and just mush. She stated she took one tiny bit and the broccoli tasted water soaked. She stated the chicken was okay, but a little dry. Resident #90 stated when they served chicken noodle soup, the soup was more liquid and not a good tasting broth and the soup only had a few noodles and a bite of chicken in it. She stated since the new company took over the food, the quality of the food had stayed the same and even though they said they tried to make it better. She stated they rarely offered fresh fruit like apples or oranges, and if served bananas they were placed on top of a bowl of pudding. Resident #90 stated she wanted fresh food in her diet.</p> <p>The facility policy titled SEIRMC-WB [NAME] Center Dietary Guidelines dated 7/2022, directed the following:</p> <p>11. Hot-cooked foods will be held at temperatures above 140 degrees. Food temperatures will be monitored and recorded on logs.</p> <p>12. Random testing of food temperatures will be done regularly, and logs maintained of all temperature.</p> <p>16. Steam tables will keep food above 140 degrees and will be maintained in a safe, sanitary condition.</p>		