STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165197	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Falls Health Care Center	1728 West Eighth Street Cedar Falls, IA 50613

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 42133 Based on observation, clinical record review, policy review, manufacturer's instructions for use and staff interviews, the facility failed to ensure a medication error rate of less than five percent when administering insulin to a diabetic resident via insulin pen for 2 of 2 residents sampled (Residents #8 and #32). The Facility reported a census of 38 residents. Findings include: 1. On 12/10/24 at 8:18 AM, observed Staff F, Registered Nurse (RN), review Resident #8's Electronic Medication Administration Record (EMAR). Resident #8's December 2024 EMAR listed the following physician orders: a. Tresiba (insulin) Flex Touch Subcutaneous Solution Pen injector 100 Units (U)/Milliliter (ML). Inject 20 units subcutaneously one time a day related to type 2 Diabetes Mellitus (DM) with unspecified complications. b. Fiasp (Insulin) Pen Fill Subcutaneous Solution Cartridge 100 U/ML. Inject 15 unit subcutaneously three times a day related to type 2 DM with unspecified complications. At 8:19 AM Staff F dialed the dose selector button on the Fiasp insulin pen to 15 units and the Tresiba insulin pen to 20 units. Staff F failed to prime the insulin pens with two units of insulin to ensure Resident #8 would receive the full physician ordered dose of insulin. Staff F administered the Fiasp and Tresiba insulin to Resident #8. The December 2024 EMAR reflected a blood sugar of 169 on 12/10/24. During an interview on 12/10/24 at 2:48 PM Staff G, Licensed Practical Nurse (LPN), explained the nurse needed to prime the insulin pens with 2 units of insulin prior to setting the dial to the physician ordered amount of insulin to be administered. During an interview on 12/11/24 at 3:55 PM the Director of Nursing (DON) reported she expected the nurses to follow the manufacturer's directions for priming the insulin pen prior to administration. She couldn't recall if they did any in service education on insulin pen administration. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Insulin Administration Policy, revised September 2014, lacked direction on how to prime an insulin pen and/or how to administer insulin via a pen. The Manufacturer's Fiasp Flex Touch Instructions for Use directed to turn the dose selector to 2 units. Hold the pen with the needle pointing up. Tap the tip of the pen gently a few times to let any air bubbles rise to the top. Hold the pen with the needle pointing up. Press and hold the dose button until the dose counter shows 0. The 0 must line up with the dose pointer. They should see a drop of insulin at the needle tip. Once completed the dose can be selected. The Manufacturer's Tresiba Flex Touch Pen Instructions directed to prime the pen. Turn the dose selector to 2 units. Press and hold the dose button until the dose counter show 0. Make sure a drop (of insulin) appeared (at the tip of the needle). 2. During an observation on 12/10/24 at 9:47 AM Staff F reviewed Resident #32 December 2024 EMAR sliding scale insulin (SSI) order: a. Insulin Aspart Flex Pen 100 U/ML Solution pen injector, inject as per sliding scale: if 0 - 149 = 0 units; 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; less than 60 or greater than 400 Notify provider, subcutaneously three times a day related to type 2 DM without complications. Staff F voiced Resident #32 required 8 units of SSI insulin. Staff F set the Insulin Aspart Flex Pen to 8 units without priming the pen with 2 unit of insulin per the manufacturer's recommendations. After Staff F, set the insulin pen, they handed the pen to Resident #32 who injected himself with the insulin. A 12/10/24 review of the Order Summary Report signed by the Provider on 10/31/24 revealed a current physician order for Insulin Aspart Flex Pen SSI. The December 2024 EMAR reflected Staff F signed off the insulin administration and included a blood sugar result of 347 for 12/10/24. The Insulin Aspart Manufacturer's Instructions for use directed to perform an air shot before each injection. Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing, turn the dose selector to 2 units. Hold the flex pen with the needle pointing up. Tap the cartridge gently with your finger a few times to may any air bubbles collect at the top of the cartridge. Keep the needle pointing upward and press the push button all the way in until the dose selector returns to zero. A drop of insulin should appear at the needle top. Once the dose selector returns to zero, turn the dose selector to the number of units to inject.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42134 Based on observation, policy review, and staff interview the facility failed to serve hot food at a temperature of at least 135 degrees Fahrenheit (F) for 1 of 1 test tray requested. The facility reported a census of 38 residents. Findings include: The facility provided a test tray on 12/10/24 at 12:06 PM. The food temperatures measured the following: a. The casserole temperature - 55 degrees Celsius (C) or 131 degrees F. b. The beans temperature - 47 degrees C or 116.6 degrees F. Staff C, Dietary, confirmed she took the temperatures in Celsius. She reported she didn't know what the expected temperature of the food should measure. During an interview on 12/10/24 at 1:01 PM, the Dietary Manager explained they should serve the hot food at a temperature of at least 154 degrees F. The facility policy titled Food Preparation and Service, last revised October 2017, directed the staff to maintain hot food temperatures above 135 degrees F.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42134 Based on observation, policy review, and staff interview the facility failed to ensure all staff entering the kitchen had their hair contained in a hair net for 2 of 2 observations. The facility reported a census of 38 residents: Findings include: During an observation on 12/9/24 at 10:01 AM, Staff A, Certified Nurse Aide (CNA), without wearing a hairnet, entered the kitchen, walked in front of the steam table to the coffee machine, filled a cup and exited the kitchen. During an observation on 12/10/14 at 11:18 AM, Staff B, CNA, entered the kitchen. She put a hair net on the top of her head, without containing all of her hair. The hairnet didn't contain the hair on the sides and back of her head. She walked around the steam table, got some ice out of the ice machine, opened a refrigerator, took out a pitcher of what appeared to be iced tea, set the pitcher on the prep table, had the cook cover the pitcher with plastic wrap, and exited the kitchen. During an interview on 12/12/24 at 9:58 AM, the Dietary Manager explained she expected all staff entering the kitchen to wear a hair net. Facility policy titled Preventing Foodborne Illness Employee Hygiene and Sanitary Practice, dated October 2017, directed hair nets must be worn.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42133 Based on observation, clinical record review, policy review, and staff interview the facility failed to adhere to infection control practices while administering medication. Observations of the nursing staff revealed they touched medication with their bare hands during medication administration for 2 of 4 residents observed for oral medication pass. The facility identified a census of 38 residents. Findings include: 1. During an observation on 12/10/24 at 7:42 AM Staff E, Certified Medication Aide (CMA), failed to perform hand hygiene prior to setting up Resident #13 morning medications after she went to the kitchen to get them a supplement. Staff E unlocked the medication cart, opened the drawer and obtained Resident #13's medication cards placing them on top of the medication cart. Staff E held each medication card in her left hand and punched the pill out the back of the card into her right hand, then placed the pill into the medication cup. Staff E continued to utilize this technique for setting up the following medications for Resident #13 in addition to administration of stock bottle medication: a. Ferrous sulfate (iron) 325 milligrams (MG) one tablet. b. Abilify (antipsychotic medication) 5 MG one tablet c. Atorvastatin (cholesterol lowering medication) 20 MG one tablet d. Fluoxetine (antidepressant medication) 40 MG one tablet e. Levetiracetam (Keppra, antiseizure medication) 500 MG one tablet f. Vimpat Oral Tablet (anticonvulsant medication) 100 MG one tablet g. Aspirin (ASA) 81 MG delayed release one tablet. Staff E removed a stock bottle out of the medication cart, shook multiple tablets into the cap, then placed her right thumb over all but one of the tablets as she flipped the lid over and placed one of the ASA tablets into the medication cup. Staff E placed the rest of the ASA tablets they touched back into the stock bottle and placed it in the medication cart. On 12/10/24 at 7:48 AM watched Staff E touch the medication cart to lock the cart; shut down the computer screen with her right hand; ensured she had her keys to the medication cart and proceeded to walk to Resident #13 room. Staff E knocked on the door and entered Resident #13's room. When Staff E handed the medication cup to Resident #13, she said she needed to have her Levetiracetam broke in two so she could swallow the medication. With her bare hands, Staff E picked the Levetiracetam out of the medication cup, broke the tablet between her right and left thumbs, then placed the tablet back in the medication cup. Resident #13 proceeded to swallow her medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #13's December 2024 Electronic Medication Administration Record (EMAR) reflected Staff E signed out the administration of the medications on 12/10/24. 2. On 12/10/24 at 7:56 AM, observed Staff F, Registered Nurse (RN), exit a resident's room, perform hand hygiene, touch keys to unlock the medication cart, open the computer screen to review residents for medication administration, and open a drawer to remove Resident #3's medication cards from the medication cart. Staff F took Resident #3's Lexapro (antidepressant medication) 50 MG tablet from the medication cup with his right bare hand and placed into a pill splitter. Staff F split the pill in half; picked the pill out of the pill splitter with his bare left hand and placed the Lexapro medication in the medication cup. Staff E voiced they aren't supposed to have to split medications, but every now and then they have to depending on what the pharmacy sends. Staff E gave Resident #3 the medication at 7:59 AM. Resident #3's Order Summary Report signed by the Provider on 10/31/24 included a current physician order for Lexapro 25 MG one tablet daily for major depression. Resident #3's December 2024 EMAR included Staff E's signature for the morning medications on 12/10/24, indicating they administered them. During an interview on 12/10/24 at 2:48 PM Staff G, Licensed Practical Nurse (LPN), voiced the staff must not touch the residents' medications with their bare hands. If they need to touch a pill to break it in half, or to put in the pill splitter, then the nurse should put on gloves before handling the medication. During an interview on 12/11/24 at 3:59 PM the Director of Nursing explained no one should ever touch the oral medication with bare hands. She expected the nurse or CMA to put on a glove before touching oral medications. The Administering Medications Policy, revised 2012, provided by the facility, directed staff to follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.