

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/24/2025
NAME OF PROVIDER OR SUPPLIER  Corydon Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE  745 East South Street Corydon, IA 50060	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>Based on clinical record review and staff interviews, the facility failed to provide a private pay resident being discharged to another facility, their unused medications and controlled medications (Resident #2). The facility census was 52 residents.</p> <p>Findings include:</p> <p>According to a Minimum Data Set (MDS) with a reference date of 12/6/24, Resident #2 had a Brief Interview for Mental status (BIMS) score of 13, indicating an intact mental status. Resident #2 required dependent assistance with transfers, mobility, dressing, toilet use, and personal hygiene needs and was frequently incontinent of bladder. Resident #2's diagnoses included cerebrovascular accident (stroke), congestive heart failure, atrial fibrillation, renal insufficiency, arthritis, and gastroesophageal reflux disease.</p> <p>Review of Resident #2's June medication administration record (MAR) found her to be prescribed several medications to control pain and anxiety including Lyrica 50 milligrams daily at night, Hydrocodone/Tylenol 5/325 milligrams every 6 hours as needed for pain, and Lorazepam 0.5 mg every 12 hours as needed for anxiety. The June MAR demonstrated the use of as needed Hydrocodone/Tylenol 5/325 milligrams was generally two doses a day with the last dose given on 3/11/25 at 10:10 a.m.</p> <p>In an interview on 6/24/25 at 10:00 a.m. the Administrator from the facility in which Resident #2 was transferred to on 3/11/25, stated when Resident #2 arrived, she was without any of her medications, including pain medications which she relied upon to control her pain. The Administrator stated she contacted the facility and was informed their protocol on discharge was to send back prescribed medications and to destroy controlled medications. The Administrator informed the facility that the resident was private pay and paid for her medications and therefore the medications were her property and they did not have the right to withhold or destroy her medications. The Administrator stated in addition, because the medications were recently refilled, Resident #2's insurance would not pay for re-fills, leaving her without any pain medication. The Administrator stated the following morning she went to their pharmacy and was able to get the refills, but noted Resident #2 was without pain medications for over 10 hours.</p> <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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/24/2025
NAME OF PROVIDER OR SUPPLIER  Corydon Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE  745 East South Street Corydon, IA 50060	
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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/24/25 at 10:20 a.m. the Director of Nursing (DON) stated the normal process when discharging a resident would be to send back unused medications to the pharmacy and to destroy controlled medications. This was the process the facility followed when discharging Resident #2 to another facility. The DON stated Resident #2 was private pay and paid for her own medications. The DON stated on 3/11/25 they received a call from the receiving facility questioning where Resident #2's medications were? The DON stated she explained and the following day Resident #2's spouse drove up and picked up her medications. The DON noted the facility reimbursed Resident #2 for the controlled medications they destroyed. The DON stated she later was shown facility policy on Discharge Medications in which it was acceptable to send controlled medications with a discharged resident. The DON stated she was unaware of that policy until shown.</p> <p>According to the facilities Discharge Medications policy; #3. controlled substances shall not be released upon discharge of the resident unless permitted by current state law governing the release of controlled substances and as authorized (in writing) by the resident's attending physician.</p>		