STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165233	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Park Nursing & Rehab Center of Jefferson	100 Ram Road Jefferson, IA 50129

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on pharmacy interview, staff interviews, policy review and clinical record review the facility failed to keep accurate account of narcotic medications for 2 of 3 residents. On 8/12/24, staff discovered that Resident #1 had 8 milliliters (ml) of morphine missing, and Resident #2 had 12 ml missing. Staff admitted that they did not always look at the bottles at shift change before documenting the amount of remaining liquid morphine. Documentation of narcotics administered was inconsistent between the paper chart and the electronic chart for Resident #1 and #2. The facility reported a census of 39 residents. Findings include: 1) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #2 was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficits). She required substantial assistance with dressing and showering, and was totally dependent for transfers. The census tab showed that Resident #2 was admitted to Hospice services on 5/2/24. A Progress Note dated 8/12/24 at 9:31 PM, showed that Resident #2 passed away at 7:45 PM that evening. The Care Plan for Resident #2, revised on 6/12/24, showed the she had impaired cognitive function and impaired ability to understand related to dementia. Staff were to administer medications as ordered and monitor for side effects. She was at risk for pain and discomfort related to a fractured ankle. Her diagnosis included: dysphagia, at risk for aspiration pneumonia, airway obstruction and dehydration. She elected to receive hospice care due to a terminal condition. The electronic Medication Administration Record (MAR) for Resident #2 showed an order dated 5/3/24 at 11:00 AM, for morphine sulfate solution 20 milligrams per milliliter (mg/ml) give 0.25 ml every 4 hours as needed (PRN) for pain or shortness of breath. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Individual Residents Controlled Substance Record (RCSR) for Resident #2, 30 ml of morphine was delivered to the facility (the document lacked date of delivery.) The RCSR showed that Resident #2 had 8 doses in May, none in June, 1 dose in July and 15 doses in August. The electronic MAR showed that no morphine had been given in the month of July, and just 14 doses in the month of August. According to the RCSR, on 8/12/24 at 7:30 PM, there was 24 ml remaining in the bottle of morphine (date of the residents passing). The Disposition of Remaining Doses showed that 12 ml had been destroyed by two nurses, the documentation was not dated. 2) The MDS assessment dated [DATE] for Resident #1, showed that she was admitted to the facility on [DATE]. She had a BIMS score of 0 (severe cognitive deficit). The resident was totally dependent on staff for eating, showering, dressing and transfers. She was receiving hospice services and had diagnosis that included; coronary artery disease, Alzheimer's Disease, cerebrovascular accident (CVA), Parkinson's Disease and bipolar disorder. The Care Plan for Resident #1, updated on 6/21/24, showed that the resident was at risk for discomfort related to contractures, stiffness in joints and Parkinson's. Staff were directed to administer pain medication and evaluate for effectiveness. Resident #1 elected for hospice care due to a terminal condition. The MAR for month of July 2024 showed Resident #1 had an order dated 12/17/2021 for morphine sulfate solution 5 mg/ml, give 0.25 ml every 4 hours PRN for breakthrough pain as resident allowed. On 9/10/24 at 12:01 PM a representative from the pharmacy said that they delivered one bottle of 30 ml morphine on 7/8/24 for Resident #1, and that was the first time they sent morphine to the facility for that resident. The RCSR for Resident #1 showed that the morphine was used 7 times in July and 1 time in August. The MAR for July showed that the morphine had been administered 6 times in July and not at all in August. The Individual RCSR for Resident #1 showed that after a dose of morphine was administered on 8/11/24 at 9:15 AM, the bottle contained 28.00 ml. On 8/12/24 at 2:30 PM, Staff F, Licensed Practical Nurse (LPN) and Staff E, Assistant Director of Nursing (ADON) signed a note that stated: bottle spilt and corrected with 20 ml remaining. On 9/11/24 at 8:05 AM, the Administrator displayed the used morphine bottle for Resident #1 and it was found to have 19-20 ml of fluid remaining. The label indicated that it had been delivered on 7/8/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility investigation titled DIA (Department of Inspections and Appeals) Report, on 8/12/24 Staff F was on the north wing caring for Resident #2 and went to draw up a 0.25 ml dose of morphine. She double checked the bottle and found that there was 12 ml in the bottle, and according to the RCSR, there should have been 24.25 ml. The ADON looked at the MAR, compared it to the RCSR and concluded that the medication had been given enough times to account for the difference of 12 ml. Upon investigation on 8/13/24, the Administrator discovered that Resident #1 had 8 ml less in the bottle than what was documented and the ADON assumed that some had been spilled so she signed the narcotic sheet saying that some of the liquid had spilled. Further investigation revealed that 5 out of the 6 nurses that worked on that medication cart that was missing the morphine, admitted that they did not look at the bottle at shift change when they completed the narcotic count. On 9/10/24 at 8:55 AM, Staff F said that she administered medication on 8/12/24 and discovered that 2 of the bottles of morphine were off by large amounts. She told the ADON, they look at bottles together and she left it with the ADON to deal with from there. On 9/10/24 at 1:37 PM, the ADON said that Staff F brought it to her attention that there was morphine missing. She said that she just thought that it was a matter of nursing mistakes in documentation and not a possible drug diversion. She decided to correct the count on the narcotic sheet for Resident #1 to indicate 8 ml less, assuming that some must have spilt. She acknowledged that she should not have entered wrong documentation and that she had been disciplined for those actions. On 9/10/24 at 3:22 PM, Staff B, LPN acknowledged that she worked on 8/10, 8/11 and 8/12/24. She said that on Sunday (11th), she noticed the morphine was low for Resident #2, but didn't compare the measurements. She said it was a busy day with a resident fall, and there was only one aide to help. She said that the morphine bottles didn't have accurate measurements to begin with, so the nurses assume that it will be off. She said that she hadn't ever given morphine to Resident #1, because she didn't like to take medicine. On 9/10/24 at 3:28 PM, Staff C, LPN said that she witnessed Staff D, RN (was the DON at the time), at the beginning of her shift take all the scheduled narcotics for the residents and put them in one cup for the shift to administer later. There were about 8-9 tabs in the cup. She said that she didn't report this because she was my boss. On 9/10/24 at 4:26 PM, Staff A, RN said that she had given morphine to Resident #1 when she would express pain. The resident didn't like to take medication, she would tighten her lips or spit it out. Staff A said that she always looked at the medication and verified what was left in the bottle or bubble pack at shift change. Some may say it doesn't matter because the fluids were always off by a fraction, but she looked at it anyway, with a second nurse. She said there had been times where a nurse may say she already counted but Staff A insisted that they count them together. On 9/10/24 at 3:49 PM. Staff D, RN said that on the weekend of 8/11/24, there was a resident that was close to the end of life and was getting more morphine. She had worked the day shift; 6 AM - 6 PM, and on the 2-10 PM shift they were short staffed and she was the only one passing pills. She admitted that the job is stressful and she had tried to save time by preparing the scheduled narcotics at the beginning of the shift and putting them all in one cup. She acknowledged that this was not an accepted practice for medication administration, but she knew the residents well enough and what medicine they had. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 11:21 AM, the Administrator and the Nurse Consultant said that as soon as they learned about the missing morphine, they did a complete audit of the narcotic documentation going back to January. They said that they would do monthly audits of the narcotics, beginning with a report from the pharmacy on what has been delivered. According to a facility policy titled: Controlled Substances, dated 2012, the facility would comply with all laws regulations and other requirements related to handling, storage, disposal, and documentation of controlled substances. Nursing staff must count controlled medications at the end of each shift. They must document and report any discrepancies.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, staff interview, policy review and clinical record review the facility failed to safely store liquid narcotic medications for 1 of 3 residents reviewed (Resident #3). Staff F left two liquid narcotic medications in the top drawer of the medication cart under a single lock. The facility reported a census of 39 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #3 had a Brief Interview for Mental Status (BIMS) score of 6 (severe cognitive deficit). She required substantial assistance with dressing, sit to stand and transfers. Her diagnosis included; diabetes mellitus, Alzheimer's disease, aphasia, cerebrovascular accident and fibromyalgia. The Care Plan for Resident #3, updated on 7/25/24, showed that she was at risk for elopement and was in the locked unit. She had elected for hospice care due to terminal condition and staff were to administer medications as ordered. On 9/10/24 at 8:06 AM a medication cart was sitting in the dining room area. Staff F, Licensed Practical Nurse (LPN) was on the opposite side of the room and then came over to the cart. When asked to count the narcotics and verify with the paper documentation, Staff F pulled a bottle of morphine out of the top drawer for Resident #3 and then pulled out a bottle of Ativan. The rest of the narcotics were in a separate, locked drawer in the cart. When asked why the two Scheduled medications for resident #3 were not double locked, she said that the resident was transitioning, so they were using them more often and it was more convenient. She acknowledged that they should have been double locked and then put them in the locked narcotic drawer. On 9/11/24 at 11:21 AM, the Nurse Consultant said that they would expect that the morphine and the Ativan for Resident #3 would be kept under two locks and not in the top drawer with other medication for convenience. A facility policy titled: Controlled Substances, revised in 2012, showed that the facility would comply with all laws, regulations and other requirements related to handling, storage, disposal and documentation of controlled substances. Controlled substance would be stored in the medication room in a locked container, separate from containers for any non-controlled medications. The container must remain locked at all times except when it was accessed to obtain medications for the resident.