STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165320	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zearing Health Care, LLC	404 East Garfield St Zearing, IA 50278

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and facility policy/procedure review, the facility failed to follow the 5 rights of medication administration and physician orders to prevent a medication error from occurring. On 5/3/25, during the morning medication pass, a Registered Nurse (RN) took Resident #2's oral medications and gave them to Resident #1. The facility reported a census of 34 residents. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] reflected they could usually make themselves understood and understood others. The MDS identified a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. The MDS listed Resident #1 as dependent in all activities of daily living (ADL). The MDS included diagnoses of non-Alzheimer's dementia and Huntington's disease. The Care Plan included Focuses of: a. Revised 2/26/20: Resident #1 has impaired cognitive function/dementia or impaired thought processes related to Huntington's Disease. The Interventions directed the following: i. Needs assistance with all decision making. ii. Administer medications as ordered. The Employee Counseling/Disciplinary Form dated 5/3/25 at 11:00 AM labeled Incident Description, documented on 5/3/35 approximately 11:00 AM, Staff A, Registered Nurse (RN), administered a noon does of clonazepam (a medication to treat seizures and panic disorder) 2 milligrams (mg) and Hydroxyzine 25 mg (used to help manage anxiety and tension) intended for Resident #2 to Resident #1 in error. Staff A identified the error approximately 10 minutes later when they went to document the medication administration in the electronic Medication Administration Record (MAR) and noted Resident #2's photo did no match the individual who received the medication. Upon recognizing the error, Staff A, immediately followed protocol. She notified the administrative staff, on-call provider, and Resident #1's family. She did a full assessment of Resident #1 and found no adverse reactions at the time. Staff A contacted the pharmacy to replace the administered medications. Staff A documented the incident per facility protocol, and submitted a medication error report. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Health Status Note 5/3/25 at 1:25 PM, identified at 12:40 PM, the staff discovered Resident #1 received 2 milligrams (mg) clonazepam (antianxiety medication) and 25 mg hydroxyzine (anti-itch medication used to treat anxiety) which he didn't normally get. The staff immediately assessed Resident #1. The assessment revealed the following vital Signs: a. Blood pressure (BP) - 94/58 (average 120/80) b. Temperature - 97.5 (average 98.6) c. Pulse - 92 (average 80 - 100) d. Respirations - 18 (average 12 - 20) e. Oxygen saturation - 96% on room air (average greater than 90%) Resident #1 didn't display any signs or symptoms of pain/discomfort. The staff notified the Advance Registered Nurse Practitioner (ARNP) and Power of Attorney (POA). The staff received an order to monitor for 48 hours, then continue to monitor per facility protocol. The POA reported she would call back later in the day to check on Resident #1, and would follow up with any changes. An email to the attending physician dated 5/3/25 at 1:37 PM, indicated the facility sent a quick update that Staff A gave Resident #1, Resident #2 noon medications. (clonazepam and hydroxyzine). Per protocol, they notified the provider and submitted a medication error report. They monitored Resident #1 closely, and he had vitals at baseline with no noticeable lethargy or reaction noted. They planned to continue to monitor. On 5/4/25 at 9:13 AM, the attending physician replied, thank you duly noted. The Health Status Note dated 5/3/25 at 4:52 PM indicated the staff assessed Resident #1 due to noted lethargy (sleepiness) and decreased interactivity when staff approached him to get him up from his nap to have supper. The assessment reflected the following: a. Temperature - 97.0 b. Pulse - 70 c. Respirations - 15 d. Blood Pressure - 123/68 e. Spo2 - 98% on room air. Resident #1 had his head of bed (HOB) elevated. The staff repositioned Resident #1 and noted his pupils as equal and reactive to light. Resident #1 opened his eyes but didn't respond to questions or react to verbal stimuli. The note described Resident #1's color as pink, with warm and dry skin. Resident #1 had even respirations with noted audible (loud breath) chest congestion (a gurgle sound). The staff documented no coughing or sobbing noted. The staff spoke with the facility's on call-provider to discuss Resident #1's condition. They instructed to monitor for the time being. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Health Status Note dated 5/4/25 at 12:18 AM identified Resident #1 as more and more alert when the nurse looked in on him to assess his condition that night. The nurse did several checks with vital signs, neuro checks and providing stimuli to assess resident responsiveness and level of consciousness. Resident #1's vital signs remained with in normal limits with each assessment and by the end of the shift, he responded with change in affect (facial expression). The nurse held Resident #1's medications as they didn't notice he could swallow safely. The nurse attempted to give Resident #1 small sips of thickened water but he didn't swallow. The staff left Resident #1's HOB left up and planned to attempt more as he became more alert. The note included the following vital signs: a. Temperature - 96.9 b. Pulse - 69 c. Respirations - 18 d. Blood Pressure - 120/52 e. Spo2 - 96% on room air. The Health Status Note dated 5/4/25 at 1:34 PM reflected the facility continued monitoring Resident #1. He had episodes of lethargy that shift but did respond at times, he had a decreased appetite noted, but had vital signs within normal limits (WNL). He didn't interact much with staff, but didn't have signs or symptoms of pain or discomfort. They facility planned to continue to follow-up. The Health Status Note dated 5/5/25 at 12:20 AM, described Resident #1 as alert and reactive, responding per his baseline (how he usually acts). The nurse assessed some mild audible congestion in his lungs, however he can cough and clear the congestion. Resident #1 didn't get up for dinner that night but received fluids and medications late that evening. The Health Status Note dated 5/5/25 at 3:55 AM described Resident #1 as awake, responding, and smiling earlier in the night shift. He awoke easily and had no visible signs of pain or discomfort noted. The Health Status Note dated 5/5/25 at 2:49 PM described Resident #1 as awake and alert that shift. He interacted with staff. He did have delayed swallowing at the morning meal, but had no other complaints or concerns that shift. 2. Resident #2's MDS assessment dated [DATE], identified a BIMS score of 9, indicating moderately impaired cognition. The MDS included diagnoses of non-Alzheimer's dementia, Huntington's (a disease passed on from family that causes breakdown of the brain's nerve cells. The illness is rare, it causes uncontrollable movements, changes in behavior and memory) disease, anxiety and difficulty in walking. The MDS documented Resident #2 received antipsychotic, antianxiety and antidepressant medications in the lookback period. The Care Plan Focus initiated 6/14/21 indicated Resident #2 had anxiety related to an altered mentation (changes in behavior, alertness, and memory) and changes in the environment. The Interventions directed to: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Administer his medications per the physicians' orders b. Takes hydroxyzine, this medication is an anti-anxiety, also takes clonazepam, this is an anti-convulsant and has a black box warning. c. Concomitant (Use of multiple medications) use of benzodiazepines (antianxiety medications) and opioids (controlled pain medications) may result in profound (extreme) sedation (tiredness), respiratory depression (inability to breath), coma (inability to wake up from sleep), and death. Reserve (try to not use) concomitant prescribing of those drugs for use in patients who had inadequate alternative treatments options. Limit dosages to the minimum required. Follow patients for signs and symptoms of respiratory depression and sedation. The Progress Notes lacked documentation of a medication error on 5/3/25. On 5/29/25 observed Staff A during the medication pass. She followed the 5 rights for administration of medications and followed the physician orders as written. On 5/29/25 at 1:00 PM, Staff A reported around 11:00 AM, she took medications out of the medication cart and proceeded to get them ready for Resident #2. Staff A explained that as they went to Resident #2, they accidentally gave the medication to Resident #1. Staff A, stated they knew right away the medication error occurred. They called the on-call provider, Director of Nursing (DON), and Resident #1's family. Staff A, explained they received the education for the 5 rights of medication administration and following physician orders. On 5/29/25 at 2:15 PM, the DON verified they expected the nursing staff to follow the physician's orders as written and follow the medication administration policy for the 5 rights. The Medication Administration Policy dated January 2025 described the purpose of the policy as to ensure safe, accurate, and consistent administration of medications to residents in the nursing home in compliance with professional standards of practice, Federal, and State regulations. The policy applied to all licensed nursing staff, medications aides, and other personnel authorized to handle or administer medications within the facility. The Five (plus one) Rights of Medication Administration directed the following: a. Right resident (verify two identifiers) b. Right medications (compare to MAR) c. Right dose d. Right route e. Right time/frequency f. Right documentation (document immediately after administration)