STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165336	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Allison	900 7th Street West Allison, IA 50602

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** 49976 Based on observation, clinical record review, policy review, and staff interview the facility failed to administer the appropriate dose of medication to 1 of 8 residents reviewed (Resident #17). The facility reported a census of 42 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #17 documented a Brief Interview for Mental Status (BIMS) of 13/15 indicating no cognitive impairment. It further documented diagnoses including: hypertension, heart failure, coronary artery disease, cardiomyopathy (disease of the heart muscle), and intellectual disabilities. During an observation on 3/26/24 at 8:13 AM Staff E, Licensed Practical Nurse (LPN) administered a 10 mg tablet of Lisinopril (an anti-hypertensive medication to reduce blood pressure (BP)) to the resident. Physician orders dated 3/8/24 documented Lisinopril 5 mg daily for essential hypertension. The resident's Care Plan lacked direction for monitoring signs and symptoms of hypotension (low BP) and medication side effects of the anti-hypertensive medication. The Progress Note dated 3/08/24 at 10:52 AM documented the physician's verbal order to decrease the Lisinopril to 5 mg daily as the resident's BP was still dropping low. The Progress Note dated 3/08/24 at 10:53 AM documented the order for Lisinopril Oral Tablet 5 mg to be given daily. The resident's guardian was called and informed of the order. An incident note dated 3/14/24 at 10:10 PM documented the resident stood up from a sitting position on her bed and became tipsy. Staff assisted the resident to the floor and she was assessed by nursing. There was no injury. On 3/27/24 at 12:06 PM the Administrator explained the facility lacked a policy on medication 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165336	A. Building B. Wing	03/28/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/26/24 at 2:49 PM Staff E confirmed she gave the resident the whole 10 mg tablet of Lisinopril during the morning medication pass. She confirmed the order in the computer was dated 3/08/24 for 5 mg. She acknowledged she looked right at the order and still gave the 10 mg dose. She reported that the resident's medication had not been changed since the order was given and the resident had been receiving the 10 mg tablet daily from 3/9-3/26 for a total of 18 incorrect doses. The Director of Nursing (DON) confirmed the presence of the Progress Note indicating the verbal order was received. She reported the fax to the pharmacy for the new dose was never sent. She noted the facility would follow up with a medication error report and the pharmacy called for the new dose. During an interview on 3/27/24 at 12:37 PM the DON explained she expected staff to take their time and double check the following before passing medications: resident name, the order, the MAR, and the medication card. She expected staff to give the right drug at the right time to the right patient.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 49976 Based on observation, policy review, and staff interview the facility failed to keep their hands off the drinking rim surfaces of the glasses and failed to cover foods for transport during meal service. The facility reported a census of 42 residents. Findings include: During an observation of the noon meal on 3/25/24 from 11:27 AM to 12:30 PM Staff A Registered Nurse, Staff B Dietary Aide, Staff C Certified Nursing Aide (CNA), and Staff D Certified Medication Aide served 14 glasses to 14 residents in the dining area handling the cups with fingers on the drinking rim surface of the glasses. Staff also failed to completely cover 2 desserts and failed to cover 1 dessert at all when transporting them to resident rooms. On 3/27/24 at 10:12 AM the Administrator explained the facility lacked a policy on dining or food handling. On 3/27/24 at 10:35 AM the Food Service Supervisor reported she expected staff not to touch the food on the plates or bowls when serving, and not to touch the rims of glasses residents drink off of. She expected everything on the tray for in-room dining to be covered for transport. 42134 During an observation on 3/25/24 at 11:37 AM Staff F, door greeter, served 1 cup to a resident touching the drinking rim of the cup. Staff G, cook, served 1 cup to a resident touching the drinking rim of the cup. During an observation on 3/25/24 at 11:48 AM, Staff F delivered a room tray to Resident #8. The tray was taken from the dining room to his room with the milk and dessert not covered. During an observation on 3/25/24 at 12:00 PM, Staff H, CNA, served a coffee cup to a resident by placing their palm over open surface of cup with all fingers and thumb on drinking surface of the cup. During an observation on 3/25/24 at 12:06 PM, Staff G served a resident 2 cups by placing their palm over the open surface of cup with all fingers and thumb on drinking surface of the cups.