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	08/29/2024

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** 28220 Based on observation, clinical record review, staff interview and manufacturer ' s recommendations, the facility failed to administer insulin according to manufacturer ' s recommendations for 1 of 1 residents reviewed for administration of insulin utilizing an insulin pen (Resident #36). The facility reported a census of 45 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #36 had a Brief Interview for Mental Status (BIMS) of 6 indicating severe cognitive impairment. The MDS further revealed the resident had a diagnosis of diabetes mellitus. Review of the August 2024 Medication Administration Record for Resident #36 revealed an order to inject 6 units insulin Aspart solution subcutaneously three times a day. On 8/28/24 at 11:16 AM observed Staff B, Licensed Practical Nurse (LPN) prepare Resident #36 ' s insulin pen with 6 units of Aspart insulin. Staff B failed to prime the insulin pen. Following preparation of the insulin pen, observed Staff B administer 6 units of insulin subcutaneously into Resident #36 ' s stomach. Following administration of the insulin, Staff B immediately removed the insulin pen. Review of manufacturer ' s recommendation for the NovLog FlexPen provided by the Director of Nursing (DON) documented before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: a. Turn the dose selector to select 2 units. b. Hold the NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. c. Keep the needle pointing upwards, press the push-button all the way in until the dose selector returns to 0. Further review of the manufacturer ' s recommendations for the NovLog FlexPen under giving the injection revealed the following: (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	a.Insert the needle into the skin. b.Inject the dose by pressing the push-button all the way in until the 0 lines up with the pointer. c.Keep the needle in the skin for at least 6 seconds, and keep the push button pressed all the way in until the needle has been pulled out from the skin. This will make sure that the full dose has been given. During an interview 8/28/24 at 11:34 PM the DON acknowledged Staff B, LPN failed to prime the insulin pen and failed to keep the insulin pen in place for a period of time following administration as expected. On 8/28/24 at 3:55 PM, the Administrator revealed the facility did not have specific policies related to medication administration or insulin administration as they would follow professional nursing standards.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on observation, clinical record review and staff interview, the facility failed to complete pre and post dialysis assessments for 1 of 1 resident reviewed for dialysis (Resident #32). The facility reported a census of 45 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #32 had a Brief Interview for Metal Status (BIMS) of 99 indicating the resident was unable to complete the assessment. The MDS further revealed the resident had a diagnoses of stage 5 chronic kidney disease (kidney failure and end stage kidney disease) and had received dialysis in the last 14 days while a resident at the facility. Observation on 8/26/24 at 2:15 PM, Resident #32 was out of the facility at dialysis. A Physician's order dated as active 8/2/24 at 2:00 PM, directed staff to complete a dialysis assessment after dialysis one time a day every Monday, Wednesday, and Friday. A Physician's order dated as active on 8/2/24 at 6:00 AM, directed staff to complete the dialysis evaluation prior to dialysis and once daily on non-dialysis days one time a day. Resident #32's care plan directed the following: o Resident #32 received dialysis on Monday, Wednesday, and Friday. o Resident #32 will have no signs or symptoms (s/sx) of complications from dialysis with a target date of 10/13/2024. o Assessments, vital signs and weights, if abnormal or not normal limits, will be communicated to the dialysis center prior to and post dialysis. o Dialysis port located on upper chest. o Dialysis site care per provider recommendations. o Resident #32 scheduled to have hemodialysis treatment every Monday, Wednesday, and Friday at the dialysis center. o In the event of an emergency such as a power outage or inclement weather that prevents Resident #32 from receiving dialysis as scheduled, the residents providers instructions are to: (specify what the nephrologist/dialysis center instruction has been given example special diet, medication, transport to alternate dialysis site) o Monitor/document/report PRN any s/sx of infection to access site: redness, (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	swelling, warmth or drainage. o Monitor/document/report PRN (as needed) for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Clinical record review revealed the following: 7/12/24- pre and post dialysis assessments not completed 7/15/24- pre-dialysis assessment not completed 7/22/24- pre-dialysis assessment not completed 7/24/24- pre and post dialysis assessments not completed 7/26/24- post dialysis assessment not completed 7/29/24- pre and post dialysis assessments not completed 8/2/24- post dialysis assessment not completed 8/5/24- pre-dialysis assessment not completed 8/9/24- post dialysis assessment not completed 8/12/24- post dialysis assessment not completed 8/16/24- pre and post dialysis assessments not completed During an interview 8/27/24 at 12:10 PM, the Director of Nursing (DON) acknowledged pre and post dialysis assessments for Resident #32 had not consistently been completed as expected and stated she and the Nurse Consultant had just looked at the resident's dialysis assessments. On 8/27/24 at 2:27 PM the Administrator revealed the facility did not have a specific policy for dialysis. The Administrator further revealed their Regulatory Nurse Consultant frequently referred to the pathway and sends it out when there are updates.