

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Griswold Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 106 Harrison St Griswold, IA 51535	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628</p> <p>Based on clinical record reviews, observation, staff interviews, and facility policy review the facility failed to maintain accurate medication administration documentation and obtain medications as ordered for 3/3 residents (Resident #1, Resident #2, Resident #3) reviewed. The facility reported a census of 39 residents.</p> <p>Finding include:</p> <p>1. The Minimum Data Set (MDS) dated [DATE] documented Resident #1 entered the facility on 4/17/24. The MDS also documented a Brief Interview of Mental Status (BIMS) score of 2 indicating severe cognitive impairment.</p> <p>Review of the Medication Administration Record (MAR) dated 4/24 for Resident #1 revealed an order for Olanzapine Intramuscular (IM) Solution Reconstituted (Olanzapine). Inject 5 mg intramuscularly every 8 hours for agitation for 1 day. Start Date 4/18/24 at 4:00 PM, discharge date [DATE] at 3:45 PM. Documentation on the MAR revealed a code 6 for 4/18/24 4:00 PM and 4/19/24 12:00 AM. Code 6 per chart codes indicated see Progress Notes. The Progress Notes section did not reveal what had happened with the medication.</p> <p>The Progress Notes of the Electronic Health Record (EHR) dated 4/17 to 4/19/24 documented Resident #1 exhibited extreme agitation upon admittance to the facility. On 4/18/24 the facility obtained verbal orders for Olanzapine orally twice daily. The documentation further revealed the acute hospital contacted the facility for follow-up on the resident and indicated the hospital required use of IM medication initially for the first 24 hours before changing to oral medications. The facility obtained orders from the physician on 4/18/24 at 3:11 PM for IM Olanzapine for every 8 hours for 1 day.</p> <p>Observation on 6/3/24 at 12:40 PM revealed the Resident #1 completed a medication administration pass by Staff 1, Certified Medication Aide (CMA). The medication was provided crushed in a puree medium. The resident required prompts to take the medication.</p> <p>In an interview on 6/4/24 the Director of Nursing (DON) stated the facility did not have the Olanzapine IM in their Emergency Kit (E-Kit) and required the delivery of the medication from the pharmacy. Since the resident's admission the Olanzapine IM has been added to the E-Kit. Medications were typically delivered by the pharmacy the same day when it was a new medication.</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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. The MDS dated [DATE] documented Resident #2 entered the facility on 3/19/24. The MDS also documented a BIMS score of 5 indicating severe cognitive impairment.</p> <p>Review of the April MAR for Resident #2 revealed an order for daily vitals one time a day with a start date of 4/13/24. Documentation on the MAR revealed no documentation on the morning of 4/15/24. May MAR for Resident #2 revealed an order for Rexulti Oral Tablet 2 MG (Brexpirazole). Give 1 tablet by mouth at bedtime for dementia with agitation. Start date 5/1/24 at 7:00 PM and discharge 5/15/24 at 1:30 PM. Documentation on the MAR revealed a code 6 on 5/1, 05/6, 5/7, 5/12. The clinical record lacked corresponding Progress Notes for these dates. Review of the June MAR for the Resident revealed an order for Aspirin EC Tablet Delayed Release 325 MG (Aspirin). Give 1 tablet by mouth one time a day related to Arteriosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. Start date was 3/20/24 at 6:00 AM. Review of the document revealed the medication was coded as 6 on 6/3 and 6/4 The clinical record lacked supporting documentation in the Progress Notes.</p> <p>Observation on 6/3/24 at 12:25 PM revealed Resident #2 completed a medication administration pass by Staff #1. The staff provided the medication whole with a glass of water.</p> <p>Interview with Staff #1 on 6/3/24 at 12:25 PM revealed a code 6 on the MAR refers the reader(s) to the Progress Notes of EHR for details. If the staff noted a low medication they will send a request to the pharmacy for a refill. Staff #1 stated missing medications is not a regular occurrence in the facility.</p> <p>In an interview on 6/4/24 at 9:40 AM the DON acknowledged that a code of 6 was used on Resident #2's MAR for 5/1, 05/6, 5/7, 5/12, and 5/20 without supporting documentation in the Progress Notes. The DON revealed that a code 6 may mean the medication is not available or the resident may have spit it out, as Resident #2 is known to spit medications. The code 6 on 6/3 and 6/4 the facility did in fact run out of the medication. It was expected the medication would be in the facility on 6/5/24.</p> <p>3. The MDS dated [DATE] documented Resident #3 readmitted to the facility on [DATE]. The MDS also documented a BIMS score of 14 indicating cognitively intact.</p> <p>Review of the April MAR for Resident #3 revealed orders for Tamsulosin HCl Oral Capsule 0.4 MG (Tamsulosin HCl), give 1 capsule by mouth at bedtime for BPH, start date 4/24/24 at 7:00 PM, Xarelto Oral Tablet 10 MG (Rivaroxaban), give 1 tablet by mouth one time a day for AFIB with dinner, start date at 4/24/24, and Gabapentin Oral Capsule 300 MG (Gabapentin), give 1 capsule by mouth two times a day for neuropathy, start date 4/24/24 at 4:00 PM. All 3 medications had a code 6 on 4/24/24. The clinical record lacked supporting documentation in the Progress Notes for these medications. The May MAR revealed no documentation on 5/9/24 for Gabapentin Oral Capsule 300 MG (Gabapentin), 1 capsule by mouth two times a day for neuropathy start date 4/24/24 at 4:00 PM. The May MAR revealed no vitals documented on 5/6/24, and no documentation on 5/9/24 for Carbidopa-Levodopa Oral Tablet 25-100 MG, give 1.5 tablets by mouth 4 times a day for Parkinson's, start date 4/24/24.</p> <p>An observation on 6/4/24 at 7:26 AM of Resident #3's medication administration with Staff #1 revealed the resident consumes all medications whole with a water wash.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/4/24 at 9:45 AM the DON acknowledged the use of code 6 on 4/24 for the 3 medications for Resident 3# and lack of supporting documentation in the Progress Notes. The staff stated the facility reviewed the admitting residents' medications either the day before or the day of admittance, but ordering of medications not completed until the resident admitted to the facility. The pharmacy preferred new orders to be received by 3:00 PM and once received the orders were filled and delivered to the facility. The DON stated the process for refills involved the nursing staff pulling the label off the medication, placing it on paper, and faxing it to the pharmacy. Refills were typically completed in 1-2 days. The DON developed a procedure for insulin and narcotics for 2 week reports from the pharmacy to ensure those medications did not run out.</p> <p>In an interview on 6/4/24 at 12:45 PM the Administrator stated he deferred the specifics of medication orders and refills to the DON. However the Administrator expected the facility not to run out of medications.</p> <p>Review of the Facility's Omnicare LTC Facility Pharmacy Services and Procedures Manual, dated 2017, revealed a section titled Providing Pharmacy Products and Services with a revision date of 1/1/13. The document revealed the process for contacting the pharmacy 24 hours a day, 7 days a week for medications, the use of the E-Kit, how to contact after hours if an emergency, or if alternatives are possible.</p>		