STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165399	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care Center	815 High Road Norwalk, IA 50211

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, hospital record review, guidance from The Cleveland Clinic, and staff interviews, the facility failed to draw and monitor laboratory values for one of three residents reviewed during medication administration, (Resident #81 in Stage III kidney failure who was receiving medications which had the potential to affect kidney function). Findings include: The Medication Administration Record (MAR) dated December 1, 2023 to December 31, 2023 documented Resident #81 had diagnoses including Chronic Kidney disease, Stage 3, and essential hypertension. The MAR documented the resident to be receiving Cozaar, 100 milligram (mg), an Angiotensin Receptor Blocker (ARB) medication used to treat high blood pressure, heart failure and chronic kidney disease. The MAR reflected the resident was also receiving 20 milliequivalents (MEQ) of Potassium daily and 80 mg of furosemide (also known as Lasix, a diuretic) twice daily. An article from The Cleveland Clinic, Titled Angiotensin II Receptor Blockers, review date 6/17/22 cited ARB medications are used for high blood pressure, prevention of heart attack, heart failure, stroke, fatty liver disease and kidney disease. The article listed types to ARBs to include medications that end in sartan to include Losartan potassium, also known as Cozaar. The article documented that ARBs may raise potassium levels and potassium supplements or potassium-sparing diuretics with should not be taken with ARBs. The article cites that too much potassium can lead to hyperkalemia (high blood potassium) which can lead to an irregular heartbeat and other heart problems. Review of the Resident's clinical record from the facility revealed an admitted [DATE]. A fax dated 12/18/23 revealed the facility notified the Advanced Registered Nurse Practitioner (ARNP) the resident was taking 80 mg of Lasix twice daily with no potassium orders. The ARNP responded on the same day to add Potassium Chloride, 20 meq, one tablet by mouth daily. The facility failed to note the resident to also be taking Cozaar and the ARNP did not include any lab monitoring orders when adding the potassium. The laboratory values dated 12/15/23, performed at the hospital prior to admission to the facility showed the resident to have laboratory values of: Potassium 4.2 (normal 3.5-5.1) BUN 59 (normal 6-20) (blood urea nitrogen, the test indicates kidney function) (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Creatinine 1.81 (normal 0.6-1.1) BUN/Creatinine Ration 32.6 (above 20 can indicate dehydration or kidney issues) Review of Resident #81's facility chart failed to reveal any kidney function labs drawn during her stay at the facility. Progress Notes revealed the following: 12/18/23 2:20PM Software generated Lab/Radiology Note documented as follows; The system has identified a possible drug interaction with the following orders; Cozaar Tablet 100 MG give one tablet by mouth in the afternoon fro hypertension. Severity; Moderate. Interaction: High Potassium levels (Hypoerkalemia) may occur with the combination of angiotensin antagonists and potassium products. Serum (blood) potassium concentrations should be monitored. This warning was in the residents Electronic Health Record under the Progress Notes after the following Note Text: The order you have entered Potassium Chloride ER Tablet Extended Release 20 milliequevalants (MEQ) in the morning for supplement has triggered the following drug protocol alerts/warnings Drug to Drug Interaction 1/17/24 at 2:49PM - Resident with hypertension, chronic kidney disease, chronic respiratory failure, reports dysuria. Onset today. 1/17/24 at 6:55PM - Addressed Complete Blood Count (CBC) and new order for Ferrous Sulfate (Iron) 325 mg. Recheck CBC in one month. New order for Urinalysis with Culture & Sensitivity. 1/20/24 11:25AM - Software generated warning for contraindication of medication. The system has identified a possible drug interaction with the following orders: Cozaar Tablet 100 G, give 1 tablet by mouth in the afternoon for hypertension. Severity: Moderate. Interaction: Co administration of angiotensin II receptor antagonists and Tremethoprim (an ingredient in the antibiotic Bactrim) may increase the risk of hyperkalemia (high potassium level) especially in the elderly. 1/20/24 11:25AM - ARNP addressed UA (urinalysis) results with new order for Sulfamethoxazole-Trimethoprim 800-160 mg tablet by mouth, for 7 days. 1/22/24 10:43AM - visit by ARNP. Plans noted to be Bactrim twice daily x 7 days, vital signs daily x 7 days and encourage fluids related to findings of a UTI due to Escherichia coli in urine. 1/25/24 11:00AM - visit by ARNP. Nursing reports she is having nausea, vomiting and diarrhea. Onset was yesterday. Resident denies burning with urination. She has been taking Sulfamethxazole/Trimethoprim 800/160 mg. She is having side effects of nausea/vomiting and diarrhea. Discontinue medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/25/24 12:35PM - Resident called her daughter. Daughter called 911. Paramedics showed up. This nurse went with them to resident's room, daughter was on Speakerphone. Nurse explained to daughter that the ARNP had a new order for Reglan. Paramedics asked why 911 was called. Resident stated I need to be fixed, they just keep giving me pills. Paramedics asked daughter if she was the Power of attorney and she stated Yes. They asked if she wanted the resident sent to hospital, she stated yes. Resident was transported to hospital downtown at 12:30 per daughter's request. Other floor nurse stated to paramedics and called resident's son and stated to him also that there was no medical reason for her to be transported to the hospital and the facility would not pay for the transport bill. Resident stated That is ok, I have insurance. 1/25/24 5:07PM - Called hospital to check on resident. Resident diagnosis kidney failure and critical labs, being admitted to Critical Care Unit. The Emergency to Hospital Admission record of Resident #81 documented laboratory values taken on 1/25/2024 as follows; Potassium 7.8 (prior was 4.2) BUN 103 (prior was 59) Creatinine 5.24 (prior was 1.81). The Clinical Impression and Disposition documented the following The resident was diagnosed with hyperkalemia (high potassium), acute renal failure (a condition in which the kidneys can't filter waste from the blood) and metabolic acidosis (when too much acid accumulates in the body, causes can include kidney failure, with symptoms to include nausea, vomiting, fast breathing and lethargy). Summary of provider notes stated: Patient in acute renal failure and and having episodes of bradycardia (slow heart rate). She does need emergent dialysis and will be admitted to the ICU. On 6/26/24 at 2:04 pm, the ARNP stated Resident #81 had Stage 3 kidney failure at baseline. She stated she could not recall what labs she had ordered during the resident's stay. She stated the facility can check with the lab for that information. She acknowledged for the medications the resident was on and her diagnosis, labs should have been ordered. She recalled the resident had a Urinary Tract Infection and was placed on Bactrim (an antibiotic). The resident was having nausea and vomiting and she prescribed Reglan (an anti nausea medication). She felt the nausea and vomiting were due to the Bactrim. On 6/26/24 at 3:57 pm, The Director of Nursing (DON) stated the ARNP orders labs during visits and she reviews the resident's medications. She stated labs are only at the order of the provider and the floor nurses do not ask the provider for any labs. She stated the ARNP saw the resident the day of her hospitalization and ordered the Reglan and had no other concerns. The facility was also encouraging fluids. The DON further stated the facility does not do any routine labs. She stated the medical director does labs on a case by case basis as the individual resident's case dictates. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 4:02 pm, the Administrator stated the facility had a corporate contract with the company who employs the ARNP. She stated it is a contractual relationship. On 6/26/24 at 4:08 pm, the DON stated the only labs that were ordered for Resident #81 during her stay in the facility were a urinalysis, an A1c (a 3 month average of blood glucose levels and a CBC (a blood test that measures red and white blood cells and blood platelets).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46873 Based on observation, clinical record review, interview and drug manufacturer's administration instructions, the facility failed to administer medications at an error rate of under 5%. The survey team observed 2 errors out of the 35 medications administered. The medication error rate was 5.7%. Findings include: During observation on 6/27/24, beginning at 7:13 am, Staff B, Licenses Practical Nurse (LPN) checked the blood glucose level of Resident #75. After obtaining her blood glucose, she prepared to administer 4 units of Lispro insulin. Staff B, LPN obtained the insulin pen from her cart, turned the dose indicator to 2 units of insulin, and stated she was priming the pen. She then connected a needle to the pen, turned the dose indicator to 4 units, and used appropriate hand hygiene and gloves administered the insulin to Resident #75. The document from the manufacturer's website titled Instructions for Use, Insulin Lispro KwikPen documented pen use as follows; Priming your pen: -Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. -If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your Pen, turn the Dose Knob to select 2 units. Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the needle. After priming the pen, the instructions continue to selecting and administering the dose. On 6/27/24 at 7:26 am, Staff B, LPN asked if she had made any errors. When told about priming the insulin pen prior to placing a needle on the pen, she stated she thought the reason for priming an insulin pen was to move insulin to the top of the pen to get air out. She stated she was not aware it was to prime the needle. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation continued of medication pass and Resident #47 was observed receiving morning medications. Staff B placed her medication cart outside the of Resident #47's door and prepared her medications. Staff used appropriate hand hygiene and gloved, Staff B administered one of Resident #47's eye drops and then returned to the cart to prepare her oral medications. She prepared 8 oral medications, which included Levothyroxine, 125 micrograms. She administered the oral medications, she continued medication pass for Resident #47 as well as a third resident. Observation of medication pass which had begun at 7:13 am ended at 7:49 am. Upon reconciling all medications given during the observation, it was noted on the Medication Administration Record (MAR) of Resident #47 the Levothyroxine was scheduled to be given at 6:00 am. On 6/27/24 at 10:42 am, the Director of Nursing (DON) stated which shift administers medications ordered at 6:00 am varies by the resident preference. She stated some residents receive these medications on night shift and others prefer to wait for day shift when they are getting up for morning cares. She stated the latest a medication scheduled for 6:00 am can be administered is 7:00 am. She stated the process to administer insulin using an insulin pen would include to place the needle on the pen, draw up 2 units, hold the pen upright to prime the needle and then proceed with the insulin administration. The undated facility document titled Regency Care Center Medication Administration Times documented: One hour before and after the time on the MAR as per standards of practice are the accepted time parameters for administration of these meds.

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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. 49990 Based on observation, staff interview, and policy review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The facility reported a census of 73. Findings include: A direct observation on 06/24/24 at 8:09 AM of the facility refrigerators revealed 1 bag of broccoli stored in a clear unlabeled bag. 1 Bag of croissants stored in a clear, unlabeled bag. 1 Bag of oriental vegetable blend stored in a blue unlabeled bag. 3 bags of cake stored in a clear unlabeled bag. A direct observation on 06/24/24 at 8:17 AM of the facility freezers revealed one freezer contained chunks of what was later identified to be potato frozen to the bottom of the freezer unit. They were not contained and appeared significantly oxidized. An interview on 06/26/24 at 1:18 PM with Staff A, Dietary cook, she stated she had been made aware of the improperly stored food. She noted it should have been labeled before it was placed in storage. She stated that policy dictates improperly stored food should be disposed of immediately after being discovered. She was unaware of the spilled food in the bottom of the freezer. She stated policy is to remove any items the food spill touched, to clean the food up and use soap and water, then disinfect the surface. She acknowledged that food should not have been placed in the refrigerator without a label and that food should have been cleaned up immediately after being spilled. An interview on 06/24/24 at 8:21 AM the Dietary Manager, acknowledged that unlabeled food should not have been stored in the refrigerator. She also acknowledged the food spilled in the bottom of the freezer should have been cleaned immediately. Review of a facility document titled Refrigeration documents that food shall be stored in an organized manner and shall be maintained in their original containers unless they are considered a leftover. All leftovers shall be labeled and dated with expiration date of no more than 3 days. It further documents all refrigerators shall be checked daily by the Dietary Manager and/or his/her designee to ensure all leftovers are discarded before expiration date and all food is properly stored.