STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165438	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stacyville Community Nursing Home	413 South Broad Street Stacyville, IA 50476

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on clinical record review, staff interviews and the Resident Assessment Instrument (RAI) manual the facility failed to accurately document and submit accurate resident Minimum Data Set (MDS) Assessment for 4 of 7 residents reviewed (Resident #9, #20, #29 and #3). The facility reported a census of 31 residents. Findings include: 1. Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included diagnoses of arthritis, stage 3 pressure ulcer to left and right hip, hypertension (high blood pressure), and heart failure. The MDS reflected Resident #9 used bed rails as a physical restraint (physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body). On 7/14/24 at 2:31 PM Resident #9 reported he could get in and out of bed independently with the bed rails on. During an interview on 7/16/24 at 4:50 PM, the Interim Director of Nursing (DON) reported they shouldn't code the bed rails as a restraint on the MDS. She reported the MDS nurse is new, and is still learning. During an interview on 7/17/24 at 12:05 PM, the Administrator reported they shouldn't code the bed rails as a restraint on the MDS. She reported the facility follows the RAI manual for MDS completion. 2. Resident #20's MDS assessment dated [DATE] identified them as severely cognitive impaired. The MDS included diagnoses of hypertension, dementia, and COVID 19. The MDS lacked documentation Resident #20 received opioid medication during the look back period. Resident #20's June 2024 Medications Administration Record (MAR) reflected they received morphine (an opioid drug) during the look back period. During an interview on 7/16/24 at 4:37 PM, the Interim DON reported they should code Morphine on the MDS. (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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 7/17/24 at 11:56 AM, the Administrator reported they should code Morphine on the MDS. 3. Resident #29's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of atrial fibrillation (abnormal heart rate), coronary artery disease, and hypertension. The MDS lacked documentation Resident #29 received an anticoagulant medication during the look back period. Resident #29's June 2024 MAR indicated they received Eliquis (anticoagulant medication) during the look back period. During an interview on 7/16/24 at 4:36 PM, the DON reported they should code Eliquis on the MDS. During an interview on 7/17/24 at 11:51 AM, the Administrator reported they should code Eliquis on the MDS. 41537 4. Resident #3's MDS assessment dated [DATE] indicated they used bed rail restraints daily during the seven day look back period. The Care Plan Focus revised 3/25/24 indicated Resident #3 used physical restraint bed rails. The Resident Assessment Instrument (RAI) Manual revised October 2023, defines a physical restraint as any manual method, physical, or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. On 7/16/24 at 4:14 PM the DON acknowledged Resident #4's bed rails didn't meet the definition of a restraint. They shouldn't code them as restraints on the MDS.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review, staff interviews, and policy review the facility failed to submit a new Pre admission Screening and Resident Review (PASRR) for 1 of 1 resident (Resident #11) for review when he received new diagnoses documented in his medical record. The facility reported a census of 31 residents. Findings include: Resident #11's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of depression and psychotic disorder. Resident #11's Medical Diagnoses reviewed on 7/16/24 listed the following diagnoses: a. 7/28/21 - Major depression disorder b. 2/22/22 - Unspecified psychosis not due to a substance or known physiological condition Resident #11's current PASRR dated 3/17/20 lacked major depression disorder and unspecified psychosis not due to a substance or known physiological condition. During an interview on 7/17/24 at 11:39 AM the Administrator reported she submitted Resident #11's PASRR for review that day. The PASRR triggered the need for a Level II review. The facility provided an untitled policy dated 2023 that lacked instruction on when to submit new mental health diagnoses for PASRR review.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on clinical record review, and staff interview and policy review, the facility failed to accurately complete a comprehensive Care Plan 3 of 14 residents reviewed (Resident #9, #25 and #28). The facility reported a census of 31 residents. Finding include: 1. Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included diagnoses of arthritis, stage 3 pressure ulcer to left and right hip, hypertension (high blood pressure), and heart failure. The MDS reflected Resident #9 used bed rails as a physical restraint (physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body). On 7/14/24 at 2:31 PM Resident #9 reported he is able to get in and out of bed independently with the bed rails on. During an interview on 7/16/24 at 4:50 PM, the Interim DON reported his Care Plan should include bed rails. During an interview on 7/17/24 at 12:05 PM, the Administrator reported his Care Plan should include bed rails. She reported the facility followed the Resident Assessment Instrument (RAI) manual. She reported they didn't have a Care Plan policy 2. Resident #25's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS listed Resident #25 used a catheter. The Care Plan Focus dated 5/15/24 reflected Resident #25 had bladder incontinence. The Interventions directed the staff Resident #25 used disposable medium briefs, change every 2 hours as needed (PRN). In addition, the Care Plan included an intervention to clean peri-area with each incontinence episode. On 7/24/24 at 2:33 PM observed Resident #25 with a urinary catheter. During an interview on 7/16/24 at 4:35 PM, the Interim DON reported the Care Plan should address the use of a urinary catheter. She verbalized Resident #25 isn't incontinent of urine as she had a urinary catheter, so the Care Plan did not accurately address her needs. During an interview on 7/15/24 at 11:48 AM, the Administrator reported the Care Plan should address the use of a catheter for Resident #25. 41537 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #28's MDS assessment dated [DATE] listed an admitted [DATE]. The MDS identified a Brief Interview of Mental Status (BIMS) of 13, indicating intact cognition. On 7/14/24 at 3:45 PM Resident #28 reported she felt no one listened to her or cared about what she wants. She felt like they don't do anything and she is living in a jail. Review of Resident #28 current Care Plan on 7/16/24 lacked interventions specific to her care and treatment needs. During an interview on 7/16/24 at 4:14 PM the DON said she expected each resident have a comprehensive Care Plan with specific resident goals and interventions completed within 21 days from admission. During an interview on 7/17/24 at 11:39 AM the Administrator explained she expected a completed comprehensive Care Plan within 21 days of admission to the facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review and staff interview the facility failed to revise 1 of 1 Residents (Resident #11) Care Plan when Diagnoses of Psychosis and depression were documented in his medical record to ensure proper interventions were in place. The facility reported a census of 31 residents. Findings include: Resident #11's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of depression and psychotic disorder. Resident #11's Medical Diagnoses reviewed on 7/16/24 listed the following diagnoses: a. 7/28/21 - Major depression disorder b. 2/22/22 - Unspecified psychosis not due to a substance or known physiological condition Resident #11's Current Care Plan reviewed on 7/15/24 lacked instruction and interventions related to his major depression disorder and psychosis. During an interview on 7/17/24 at 11:39 AM the Administrator reported they reviewed Resident #11's Care Plan on 7/18/24 with a consulting agency. She added she expected a resident's Care Plan to include interventions and directions for staff related to the residents' diagnoses.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review, policy review, resident, and staff interview the facility failed to implement discharge planning upon admission for 1 of 1 resident reviewed (Resident #28). Resident #28 voiced she would like to discharge upon admission to a different facility. The facility reported a census of 31 residents. Findings include: Resident #28's MDS assessment dated [DATE] listed an admitted [DATE]. The MDS identified a Brief Interview of Mental Status (BIMS) of 13, indicating intact cognition. On 7/14/24 at 3:45 PM Resident #28 reported she wanted to go to a different nursing home in Minnesota. She felt like a prisoner at the facility. The Progress Note dated 6/14/24 at 9:25 PM reflected Resident #28 became upset and said she would like to leave the facility. The Care Plan reviewed on 7/16/24 lacked a comprehensive review and interventions for her to discharge to another facility. During an interview on 7/16/24 at 4:14 PM with the Director of Nursing (DON) reported Resident #28 needed 24-hour care due to not taking care of herself at home. The Deaths/Discharges policy, dated 2023, lacked instruction to staff on how to incorporate residents wishes and goals to discharge home.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48003 Based on time card review, schedule review, and staff interviews, the facility failed to provide a Registered Nurse (RN) in the facility for eight (8) consecutive hours per day as required by the Federal Regulations. The facility reported a census of 31 residents. Finding include: Review of all RN Timesheets from 1/1/24 thru 3/31/24 and schedules from 6/14/24 thru 7/14/24 revealed the facility failed to staff an RN on the following dates: 2/10/24, 3/9/24, 3/23/24, 3/24/24, 3/31/24, 6/16/24, 6/22/24, 6/30/24, 7/8/24, and 7/10/24. During an interview on 7/16/24 at 1:30 PM, the Administrator reported the facility thought they had a waiver for RN coverage. The Administrator learned they didn't, so the facility had times without an RN covering for 8 hours in a day.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review, facility provided education, policy review, staff and Pharmacist interviews the facility failed to provide 1 of 6 residents (Resident #1) their prescribed medications. After Resident #1 received another resident's medications, she went to the local hospital. Due to Resident #1's level of sedation, the hospital admitted her. The facility reported a census of 31 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview of Mental Status (BIMS) of 13, indicating intact cognition. The MDS lacked documentation of neurological, psychiatric, or mood disorders. An untitled statement, dated 4/11/24 reflected on 4/11/24, Resident #1 received another resident's medications consisting of: a. Benztropine mesylate (anticholinergic, helps decrease muscle stiffness and improves walking ability in people with Parkinson's disease) 0.5 milligrams (mg) b. Atorvastatin 40 mg (blocks an enzyme in the body needed to make cholesterol) c. Clozapine 300 mg (antipsychotic, change activity of substances in the brain) d. Cranberry 500 mg (intended to help prevent urinary tract infections) e. Flomax 0.4 mg (helps relax muscles in the prostate and bladder so urine can flow easily) f. Senokot 8.6 50 (increases activity in the intestines to cause a bowel movement) g. Sertraline 150 mg (increases the amounts of serotonin, a natural substance in the brain that helps maintain mental balance) Resident #1, Medication Review Report dated 4/8/24 indicated he didn't take the following medications: a. Benztropine mesylate 0.5 mg b. Atorvastatin 40 mg c. Clozapine 300 mg d. Cranberry 500 mg g. Sertraline 150 mg (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The Health Status Note dated 4/11/24 at 10:18 PM reflected Staff H, Licensed Practical Nurse (LPN), received a call related to Resident #1 sleeping in his chair since supper and the staff had hard time waking him. Staff G, Registered Nurse (RN) stated Resident #1 kept asking for his supper time medications before supper. Staff G gave Resident #1 the wrong medications, but he remained stable at that time. Staff H notified the on-call doctor that Resident #1 received the wrong medication. The on-call doctor instructed to monitor him, if his oxygen and vitals got worse send him to the emergency room (ER). Record review of Resident #1 Progress Note dated 4/12/24 a 4:24 AM documented: Resident #1 is being monitored due to being given the wrong medications, routine checks completed with vital signs and between checks resident had emesis (thrown up) and has also not urinated. Record review of Resident #1 Progress Note dated 4/12/24 at 9:28 AM documented his respirations (breaths) have increased to 36 per minute (normal 12 20 breaths per minute). Call placed to on call doctor to get ok to transfer. Record review of a Notice of Resident Transfer/Discharge for Resident #1 dated 4/12/24 documented he went to the hospital because he received the wrong medications. Record review of Resident #1 MDS log in his Electronic Health Record (EHR) informed he discharged on [DATE] and returned on 4/14/24. Record review of Resident #1 Discharge Summary from the local hospital dated 4/14/24 documented discharge diagnoses of: a. Acute COVID infection b. Inadvertent dose of antipsychotic medication, patient given dosing error causing a fair about of sedation An emailed statement completed by Staff E, Certified Nurse Aide (CNA), dated 4/15/24 at 3:16 PM reflected on 4/11/24, the facility had an agency nurse that night. Around 4:30 PM Resident #1 went to the nurses' station and asked for night time medications. At 4:45 PM, Resident #1 returned to the nurses' station, the Staff E looked up and saw Resident #1 receive more medications. When they questioned the nurse why he received more medication, as they thought he only got one thing of medication at night, the nurse responded he hesitated to give him the medication. The nurse got the Staff E at 5:15 PM that evening and went to Resident #1's room. They found him asleep in his wheelchair. Staff E told the nurse this was uncommon for Resident #1 because he hadn't eaten dinner yet. He usually ate dinner, went to his room, then got ready for bed. When they attempted to wake up Resident #1, he wouldn't wake up. The nurse didn't do anything about it, until 9:00 PM. At that time, he called the Director of Nursing (DON). Staff E expressed the nurse should have called sooner and double checked who he gave medication to. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	An emailed statement written by Staff B, Certified Medication Aide (CMA), on 4/15/24 at 3:49 PM identified when Staff G got to the facility, he asked the aide what time they give the evening and bedtime medications. He continued asking the aides who each resident was and where he could find them. Before 5:00 PM, he started giving medications in the lobby area and gave Resident #1 his Tylenol, he normally received at supper. Staff B explained she worked with 2 other staff who stopped to check the monitor, when they saw Staff G give Resident #1 a cup full of medications and asked him his name. He told him, here take these, they are your bedtime medications. Staff E asked Staff G what he gave Resident #1 as he only received 1 medication at supper. Staff E asked Staff B how many medications he received at supper, Staff B reported Resident #1 usually got 1 medication not a whole cup full. Staff B stopped Staff E and took her to Resident #1's room, when they arrived he asked if Resident #1 acted normal for him being that zonked out. Staff E got Staff B and the other staff, together they went into Resident #1's room. After looking at Resident #1, then went and told Staff G that wasn't normal for him. Staff E questioned Staff G if he gave Resident #1 his correct medications, he responded that he did give him the correct medications. He questioned why Resident #1 wanted his bedtime medications so early. Resident #1 appeared in a deep sleep, snoring, and he didn't respond to the sternum (breast bone) stimulation (deep pressure rub). The staff carried him from his chair to his recliner to prevent him from falling on the floor. The CNAs had concerns Resident #1 didn't receive the correct medications, so they reached out to the on-call nurse. Before the nurse arrived, Staff G went to Staff B and Staff E remarking that he didn't know if he gave Resident #1 the correct medications. He explained he just used the last name, not realizing the facility had 2 residents with that name. They had different first names but the first name of one matched the last name of the other. A handwritten statement by Staff D, CNA, on 4/15/24 indicated Resident #1 went to the desk to get his evening pill. Then around 5:00 PM, Staff G asked who was Resident #1. Staff D told Staff G, Resident #1 was in his room. When Staff E said, he already gave Resident #1 his medications at the nursing station. She questioned if he was looking for a different resident with the same last name as Resident #1's first name. Staff G reported he didn't give him his medications because he had them. Staff E reiterated that she saw him give Resident #1 medications. Staff G left and gave Resident #1 his medications. Then he, Resident #1, became sleepy. An undated handwritten statement by Staff F, LPN, identified on 4/11/24, she followed the agency nurse who gave Resident #1 the wrong medications. When she started working she did huddle with the CNAs and immediately went to Resident #1's vital signs. Resident #1 had increased respirations, so they check his vitals every 15-30 minutes, making sure to check his respirations and pulse every time. Staff F reported she checked the depth of his breaths and didn't find him having shallow breaths. Around 2:30 AM Resident #1's respiratory rate returned to his normal limits, so she decreased checking on him to every 30 minutes to an hour. Staff F checked his blood pressure that night 2 times with a result of 115/62 (average person - 120/80), in addition she checked his oxygen level which never dropped below 91% (average person greater than 90%). Around 4:00 AM as the staff changed him, they called Staff F into his room as he vomited. The staff cleaned him and noted his respirations increased. As Staff F called Resident #1's name, he opened his eyes but didn't verbally respond. When Staff F checked his vitals, everything remained stable except his elevated respiratory rate. Staff F believed the repositioning may have cause the increased respiratory rate. Staff F received report from Staff G around 11:30 PM that night. He gave a vague report and bounced around a lot. When talking about what happened, he stated Resident #1 repeated his name multiple times and asked multiple times for his medication. He could receive it as early as 3:00 PM and he previously asked for Tylenol, which he didn't usually do. Staff F checked the medication cart and found Resident #1's medications given. Staff G left after he gave report. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/15/24 at 12:50 PM Resident #1's Pharmacist explained she found Resident #1 received clozapine concerning as it is an antipsychotic medication and sedation would be concerning. She added based on how much he received (300 mg) it would take its full effect in two (2) hours to get to the peaks and every 12 hours it would go down and be out of his system in 3 days. She reported every person is a little different with how their body processes medications and because he used a lot of those medications, it shouldn't cause many issues. During an interview on 7/16/24 at 4:20 PM the DON reported the on-call nurse came in and assessed Resident #1 on 4/11/24. She seen him tired, but it was also bedtime. She added she came to work the morning of 4/12/24, the night shift reported nothing changed with him throughout the night as he slept, but she chose to send him out that morning as he didn't act like his normal self and she felt he needed evaluated. During an interview on 7/17/24 at 11:39 AM the Administrator confirmed she expected every resident get the right medications every day and errors like that shouldn't happen. The undated document titled, Medication Orders and Potential Errors provided by the facility to all staff after Resident #1's medication error on 4/11/24 instructed nurses on how to conduct a proper medication pass and to report a concern without fear. The Medication and Treatment Administration policy instructed all medications and treatments must have orders to administer. Make sure to complete the five (5) rights when administering medications: a. Right medication b. Right dose c. Right time d. Right route e. Right resident

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 48003 Based on staff interviews, the facility failed to provide a qualified Infection Preventionist to monitor and provide oversight to the facility infection prevention program. The facility reported a census of 31 residents. Findings include: During an interview on 7/15/24 at 12:20 PM, the Administrator reported Staff A, Registered Nurse (RN), didn't have her certification but took the class and finished it but needed to take the test. During an interview on 7/16/24 at 11:34 AM Staff A reported she took the class but didn't complete the test.