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	02/07/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25854 Based on clinical record review, resident interview, staff statements and review of Resident Rights, the facility staff failed to treat one (1) resident with dignity and respect while speaking with them (Resident #9). The facility reported a census of 28 residents. Findings include: Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. During an interview on 1/23/25 at 12:35 PM Resident #9 indicated the previous evening (1/22/25) she attempted to speak with Staff C, Licensed Practical Nurse (LPN), as she slept in a recliner in the front lounge area of the facility. Resident #9 aroused Staff C and asked her if one (1) of her duties included the management of the dining area at which time the nurse stated, no, I am in charge of meds and that is all. Resident #9 described the staff member's tone of voice as not pleasant and the failure of staff to help all Residents eat in the dining area as no big deal which pissed her off. At that point a staff member called Staff D, LPN/Assistant Director of Nursing (ADON), who arrived at the facility and escorted Staff C out of the building. According to a written statement dated 1/27/25 at 3:00 PM Staff E, Certified Nursing Assistant (CNA), confirmed she witnessed Staff C as she failed to treat an unknown resident with dignity and respect on 1/22/25 as she rolled her eyes at the resident when she requested pain medication. Review of the undated facility's Residents' Rights form instructed each resident had the right to be treated with respect and dignity.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 25854 Based on clinical record review, staff interview, and facility policy review the facility failed to report missing narcotics from the facility's emergency narcotic box within the required 24 hours. The facility identified a census of 28 residents. Findings include: Review of a facility self-reported incident #126148 I revealed on 1/15/25 the facility identified a discrepancy with the emergency narcotic lock box. The facility failed to report the missing narcotics to the Department of Inspections, Appeals and Licensing until 1/23/25 at 11:51 AM. During an interview on 1/23/25 at approximately 5:10 PM the current Interim Administrator and current Administrator indicated they failed to report the missing narcotics to the Department in a timely manner because of their investigation being progressive.

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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** 25854 Based on observations, clinical record review, staff interview, and facility policy review, the facility failed to provide adequate assessments and interventions in a timely manner for 1 of 3 residents reviewed (Resident #3) following a change of condition. The facility identified a census of 28 residents. Findings include: Resident #3's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS listed Resident #3 as always continent of bowel and bladder. The Health Status Note dated 11/4/24 at 8:00 AM indicated as Resident #3 sat at the breakfast table he started to rub his abdomen, then his entire demeanor changed. He started grimacing and when asked if he had pain he replied yes. The writer observed him for about ten minutes, he took 2 bites of his food then stopped eating. He then just sat there in pain so the writer went to him and asked him where he had pain. He rubbed his lower right side of his abdomen and the writer asked if it hurt worse when they touched it he said yes. The writer had him stand up and stand on his [NAME] toes, that made him almost fall over in pain with tears. His blood pressure went from 128/97 (average 120/80) at 7:00 AM to 178/110 at that time. The entry failed to include any further assessments such as bowel sounds, lung sounds, last bowel movement, edema and etc. The Health Status Note dated 11/4/24 at 8:40 AM reflected the facility spoke with the local emergency room (ER) staff to let them know about Resident #3 being on his way by ambulance for severe right-side pain that began around 8:00 AM that morning, he had a history of an ileus (slow movement in the intestines that may cause a blockage of the stool), he still maintained his appendix, he had elevated blood pressure, he grimaced, held his abdomen, exhibited labored breathing, and became tearful. The entry failed to include any further assessments as stated above. According to an email dated 1/28/25 at 2:16 PM the facility's Administrator confirmed she expected the facility staff to assess and document for 3 days or until asymptomatic (without symptoms) for 3 consecutive days with a condition change and/or a fall. Review of the facility's Hot Charting Guidelines form dated 7/6/23 directed the following: a. Change in general condition: Assess and document every shift until stable for any resident with a change in their general condition. b. Fall without injury: Assessments and interventions every shift for 3 days. c. Fall with injury: Assessments and interventions every shift until stable. A Change of Condition policy or procedure dated 2024 defined a resident assessment as the licensed nurse completed a head to toe assessment, including full vital signs (neuro signs if indicated).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25854 Based on clinical record review, staff interviews, and policy review, the facility failed to maintain a safe environment for one (1) resident residents reviewed (Resident #15). While assisting Resident #15, the nurse found a marijuana pipe and a medication bottle labeled Lasix (diuretic) with contents unknown in his drawer. Instead of removing the items, the nurse allowed Resident #15 to keep the items in his room with direction for his family to pick up. The facility reported a census of 28. Findings include: Resident #15's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #15 reported an occasional pain rating of 5, indicating moderate pain (based on 0 = no pain and 10 = very severe horrible). The Health Status Note dated 4/14/24 at 9:49 AM reflected as the nurse put Resident #15's wallet in his top drawer of the end table, they found a box, a pot (marijuana) pipe, a lighter, and a medication bottle labeled Lasix (antidiuretic). The nurse called Staff E, Licensed Practical Nurse (LPN), who told the nurse to tell Resident #15 they could either lock it up or have his daughter pick up the items. After the nurse told Resident #15, he replied cooperatively that he told them he wouldn't smoke there, so he didn't know why they brought it. The nurse didn't confiscate the items, but notified Staff E. The nurse reported she didn't have his daughter's phone number to call. The clinical record lacked a physician's order to use marijuana, notification to the physician that the resident had the items, or what happened to the items after that entry.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25854 Based on staff provide photograph, resident, and staff interviews, the facility failed to have a licensed nurse awake and capable of rendering nursing service for 1 day reviewed. On 1/22/24, residents and the facility saw observed Staff C, Licensed Practical Nurse (LPN), sleeping in the front lounge. The facility reported a census of 28 residents. Findings include: 1. Resident #12's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. A photo, (not time stamped) revealed Staff C as she sat reclined in a chair in the front lounge of the facility with her eyes closed. The view out the front picture window revealed it as dark outside. During an interview on 1/23/25 at 12:35 PM Resident #12 indicated she observed Staff C as she slept in the front lounge of the facility while on duty the evening prior. 2. Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. During an interview on 1/23/25 at 12:35 PM Resident #9 indicated the previous evening (1/22/25) she attempted to speak with Staff C, Licensed Practical Nurse (LPN), as she slept in a recliner in the front lounge area of the facility. Resident #9 aroused Staff C and asked her if one (1) of her duties included the management of the dining area at which time the nurse stated, no, I am in charge of meds and that is all. At that point a staff member called Staff D, LPN/Assistant Director of Nursing (ADON), who arrived at the facility and escorted Staff C out of the building. According to a written statement dated 1/27/25 at 3:00 PM Staff E, Certified Nursing Assistant (CNA), confirmed she witnessed Staff C sleep while in work status. Review of a time card revealed Staff C worked 1/22/25 from 1:52 PM until 6:29 PM. An email from the Administrator on 1/31/25 at 10:16 AM reflected Staff C didn't take a scheduled break, as it depended on their workflow. The Administrator added it is not acceptable to sleep/mediate in the lounge area of the facility.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25854 Based on clinical record reviews, staff interviews, the Iowa Nursing Board Chapter 6 regarding the Nursing Practice For Registered Nurses (RN)/Licensed Practical Nurses (LPN), the Iowa Department of Inspections, Appeals, and Licensing (DIAL) website page related to the RN/LPN Role & Scope, audio of a submitted video, and employee records, the facility failed to have competent staff to work at the facility. The facility had an LPN perform intravenous (IV) medications via a peripherally-inserted central catheter (a IV that provide medications into a large vein that can stay in for multiple months) for 1 of 1 residents reviewed (Resident #15) without an Iowa approved certification. In addition, the unqualified facility staff diagnosed a resident, they didn't know when to properly intervene when two (2) residents expressed erratic behaviors, and used an unsecure social media platform to communicate with clinic staff about resident's conditions. The facility reported a census of 28 residents. Findings include: 1. Resident #15's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of wound infection and personal history of a pulmonary embolism (blood clot in the lung). Resident #15 received an antibiotic during the lookback period. Resident #15 received on admission and while a resident IV medications of antibiotics via a central line (PICC). Resident #15's April 2024 Medication Administration Record (MAR) included the following orders: a. Daptomycin (antibiotic) intravenous solution reconstituted (daptomycin) dated 4/13/24. Use 100 milliliters (ML) intravenously one time a day for 750 milligrams (MG) in sodium chloride (NaCl 0.9%) related to an infection following a procedure, other surgical site, initial encounter for 23 days. i. Signed as administered by Staff D, Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON) on 4/26 and 4/27. b. Ertapenem Sodium (antibiotic) Injection Solution Reconstituted (Ertapenem Sodium) dated 4/12/24. Use 10 ml intravenously one time a day for skin and soft tissue infection for 23 days. i. Staff D signed on 4/26 and 4/27, indicating they administered the medication. c. Sodium Chloride (PF) Injection Solution 0.9 % (Sodium Chloride) dated 4/12/24. Use 3 ml intravenously every 12 hours for line care infuse 3 ml into venous catheter every 12 hours. i. Staff D signed the 8:00 PM record on 4/15, 4/20, 4/22, 4/26, and 4/29. ii. Staff D signed the 8:00 AM record on 4/26 and 4/27. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Health Status Note dated 5/6/24 at 1:13 PM written by Staff D indicated the provider order to remove the PICC line. The line got removed under sterile technique with pressure held for 3 minutes and a pressure bandage applied to the site. Resident #15 tolerated the removal without any complications. Staff D's Nursing Certificate of Completion dated 10/14/22 indicated they received 2 contact hours of PIV insertion and discontinuing in the Radiology Practice. The certificate indicated the facility designed the activity based on the Minnesota Board of Nursing rules for continuing education in which 1 contact hour equaled 60 minutes of learning activity. Staff D's Mayo Clinic Certificate of Completion dated 5/2/23 reflected they successfully completed the 2023 Nursing Competency: Central Lines. The certificate listed contact hours as not applicable (N/A). The bottom of the certification included the certificate denoting general completion only. The recipient is responsible for verifying that it meets requirements for practice-specific licensing or credentialing organizations. An email from the Administrator on 2/5/24 at 3:45 PM indicated Staff D learned from the Iowa Board of Nursing, she needed to take an IV class in Iowa or have approval from the Iowa Board of Nursing. The DIAL website page related to RN/LPN Role & Scope reviewed on 1/23/25 included a section labeled Expanded Intravenous Therapy Course for the LPN. Iowa law and Administrative Rule allows the LPN to perform IV therapy functions. The IV therapy course is currently offered by some Iowa Community College Continuing Education (CE) Department and other Board approved CE providers. The IV Therapy course content is based on the latest standards of practice. An approved Iowa Board of Nursing provider of nursing CE must offer the course. As of September 2021, the providers who have access to curriculum included 7 colleges in Iowa, and one specialty infusion service in Omaha, Nebraska. The list lacked any programs outside of the 8 listed, including the Mayo Clinic of Minnesota. 2. During an interview on 1/21/25 at 2:03 PM Staff A, Registered Nurse (RN), confirmed on an unknown date, she reported a change of condition for Resident #1 to Staff B, Licensed Practical Nurse (LPN). Staff B, who hadn't been in the building to perform an assessment, proceeded to diagnosis Resident # with a TIA (Transient Ischemic Attack/Stroke). Staff A confirmed the nurse's scope of practice failed to include the ability to self-diagnosis a resident. Staff A explained the task remained the responsibility of a physician. In addition, Staff A confirmed she knew Staff B used Snapchat (a non secured platform) to report condition changes and requests to the physician and/or their nurses. A video submitted by Staff A made on 10/3/24 at 12:49 PM of a conversation with Staff B and an unknown Board Member indicated Staff B admitted to diagnosing Resident #1 with a TIA because a physician indicated the resident would have another TIA within a couple days. The diagnosis upset Staff A because Staff B hadn't even been in the building. 3. According to an email 2/4/24 at 3:50 PM Staff B indicated the facility management staff/board failed to educate her on how to manage residents with erratic, psychological behaviors and/or suspected illegal drug use/abuse while they resided at the facility. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. According to an undated and untimed typed statement from Staff D, LPN/ Assistant Director of Nursing (ADON), they confirmed Staff B informed her she used the platform Snap Chat (not secured) to communicate with hospital staff and receive physician orders for a resident housed at the facility at that time. According to an email dated 2/6/25 at 8:10 AM the Interim Administrator confirmed any social media as inappropriate communication with hospitals.

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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. 25854 Based on schedule review, time card review, staff interview and facility policy review 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. In addition, the facility failed to designate a RN as the Director of Nursing. The facility reported a census of 28 residents. Findings include: 1. Review of staffing calendars provided by the facility from the conclusion of their re certification survey on 9/17/24 that identified staff concerns with inadequate RN staff hours. The facility failed to provide 8 hours of RN coverage on the following dates: 12/4/24, 11/1/24, 11/11/24, 11/18/24, 11/19/24, 11/25/24, 11/26/24, 10/7/24, 10/19/24, 9/1/24, 9/2/24, 9/8/24, 9/16/24, 9/23/24, 9/30/24, 8/10/24, 8/11/24, 8/14/24, 8/18/24, 8/19/24, 8/24/24, 8/31/24, 9/19/24, 9/20/24, 9/27/24 and 9/28/24. An email dated 1/29/25 at 5:08 PM indicated the administrative staff confirmed they failed to staff 8 hours of RN coverage per day. 2. A Quick Confirm License Verification Report form dated 12/13/23 at 5:51 PM revealed Staff B Single Contact License & Background Check form dated Staff B's, Licensed Practical Nurse (LPN)/Interim DON, employee file identified an active LPN license from 6/5/19 thru 10/15/24. The employee file revealed the facility hired Staff B on 12/13/23 as a part time charge nurse, then on 4/15/24 the facility promoted her to the Interim DON position. ON 10/10/24, the facility terminated Staff B for failure to follow the nursing standards of practice. During an interview on 1/30/25 at 2:10 PM Staff B confirmed during her employment at the facility the Provisional Administrator and the Board of Directors directed her to perform tasks outside of her scope of practice as an LPN, such as flushing PICC lines and confirmed the management staff failed to properly train her as a DON.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25854 Based on clinical record review, staff interview and facility policy review the facility staff failed to follow professional standards of practice for 1 resident reviewed (Resident #1). Staff A, Registered Nurse (RN), drew up liquid morphine, Roxanol (pain medication), without a witness in a 1 milliliter (ml) syringe. Staff B, the Interim Director of Nursing (DON)/Licensed Practical Nurse (LPN), took the syringe from Staff A and administered it to Resident #1. The facility identified a census of 28 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] indicated they received an opioid medication during the lookback period. During an interview on 1/21/25 at 2:03 PM Staff A, Registered Nurse (RN), confirmed she drew up a dose of liquid Morphine/Roxanol with no witness present and for Resident #1 (on a date unknown) and took it with her to the Administrator's office. Upon arrival and after a dispute Staff B, Licensed Practical Nurse (LPN) / Interim DON, took the syringe from Staff A, went to Resident #1's room and administered the medication without direct knowledge of the syringe contents. During an interview on 1/30/24 at 2:10 PM Staff B confirmed she administered the liquid Morphine/Roxanol as stated above. A Controlled Substances policy dated 2024 directed the facility staff reconciled (review) controlled substances upon receipt, administration, disposition (disposal), and at the end of each shift.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 25854 Based on interviews, employee records reviews, and clinical record reviews, the facility failed to provide an effective leadership to follow the required Federal Regulations and state rules of a long-term care nursing facility. The facility failed to follow the Federal Regulation to have a Registered Nurse (RN) designated as the Director of Nursing (DON). The provisional Administrator designated Staff B, Licensed Practical Nurse (LPN), as the Interim DON knowing she didn't have her RN. In addition, the facility failed to ensure proper chain of command regarding concerns with the DON. The facility reported a census of 28 residents. Findings include: 1. An undated Job Description form for an Administrator identified their supervisor as the Board of Directors. The description indicated the Position Authority and Accountability of the Administrator instructed the Administrator oversees the total operation of the facility. They initiate planning, organization, direction and control over financial and material resources in order to assure residents receive the highest possible quality of care. They function independently with extensive autonomy, within the constraints of policy, and procedure as established by the Board of Directors. The General Functions include the following: a. Assumed accountability for compliance with Federal, State and other regulations within scope of control and of which informed. b. Observed safety hazards and emergency situations, and reports to appropriate person or takes corrective action according to establish procedures, works safely without danger to self or others. c. Assured the facility operated according to established company policy and procedure In compliance with all applicable federal, state and local regulations. d. Interpreted company policies, procedures, job descriptions and other guidelines in order to meet the specific needs of the facility, while at the same time maintaining the intent and integrity of the company's practices. e. Implemented, enforced, and abided by the policies and procedures necessary to the operation of the facility. f. Assured that facility staff implemented programs and services to have met the health, nutritional, and psycho social care and activity needs of the residents. g. Serve as an in-house expert with regard to federal and state regulations and laws, company policy and procedure, and effective business and management practices. Staff B's, Licensed Practical Nurse (LPN)/Interim DON, Employee Performance Evaluation (Clinical) dated 4/15/24 reflected the Administrator moved her to the Interim DON until further notice. The evaluation listed Staff B's goals as (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. Train as a Director of Nursing b. Learn Federal and State Guidelines c. Take management courses to better job performance The Director's/Supervisor's comments documented Staff B excelled quickly and had the potential to become the DON full time permanently if she obtained her Registered Nurse (RN). The unsigned Director of Nursing Orientation form dated 2020 reflected the Supervisory Responsibilities included rules/regulations regarding Federal and Iowa Code Chapter 58. 2. During an interview on 1/21/25 at 2:03 PM Staff A, Registered Nurse (RN), confirmed she drew up a dose of liquid Morphine/Roxanol with no witness present for Resident #1 (on a date unknown) and took it with her to the Administrator's office. Upon arrival and after a dispute Staff B, Licensed Practical Nurse (LPN) / Interim Director of Nursing, took the syringe from Staff A, went to Resident #1's room and gave her the medication without direct knowledge of the syringe contents. A forwarded email written by Staff A on 10/2/24 at 9:48 AM indicated at around 10:30 AM on 10/1/24 she went to the previous Administrator's office to ask where to locate the funeral home in a resident's chart. The Interim DON arrived at the facility around 11:00 AM and took over the care for the resident. Staff A felt uncomfortable giving the resident morphine due to her condition and the family's continuous denial to allow the resident to have the morphine. Staff B gave the resident the morphine and then called Staff A to her office. While in the office Staff A felt Staff B degraded her as a nurse, told her she wasn't a strong, confident nurse, and she question too much stuff. This resulted in Staff A feeling uncomfortable with talking with Staff B. A mp4 (video file) owned by Staff A created 10/3/24 included audio with a black screen of a conversation between her, Staff B, and an unnamed board member. During the meeting the unnamed board member and the Interim DON, Staff A received guidance to show her confidence in front of a family. The unnamed board member instructed Staff A to go to the clinical management regarding a clinical related concern. He said if the staff member had concerns with the Interim DON for something other than clinical such as she was smoking pot, then she could go to the Administrator for this. The Interim DON agreed that if there was an issue bigger than the clinical then she could go to the Administrator. During the meeting, the unnamed board member discussed the provisional Administrator would be leaving the facility soon due to not fulfilling her educational requirements. 3. According to an email dated 2/4/24 at 4:50 PM sent to Staff B regarding if the facility management staff/board educated her on how to manage residents with erratic, psychological behaviors and/or suspected illegal drug use/abuse while they resided at the facility. Staff B replied on 2/4/25 at 5:26 PM she had a total of 2.5 shifts of training from an actual nurse total for her time spent there, so her answer to the question was no. An Invoice dated 5/3/24 indicated the facility got billed for 5 hours of DON training.

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	02/07/2025

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 25854 Based on facility record review and staff interviews, the facility failed to have an effective quality assurance (QA) program in place to assist in the provision of quality care for residents. See F727 for additional information regarding RN coverage. The facility identified a census of 28 residents. Findings include: The Recertification, Complaint, Incident survey dated 7/17/24 included a deficiency for F727 regarding sufficient nursing staff. The facility's submitted Plan of Correction listed a correction date as 8/16/24. The plan indicated the facility failed to schedule a Registered Nurse for at least 8 consecutive hours a day for 10 days out of 90. The facility reviewed the RN coverage for the rest of the schedule with the Staffing Coordinator for lack of RN coverage. The Administrator created advertisements, with the local newspaper, flyers in local businesses, posted to social media, and raised the starting wage for an RN. The facility requested RN coverage through staffing agency until the RN/ADON could start employment. The monitoring section indicated the Administrator, DON, or Staffing Coordinator would monitor the daily schedule to ensure the facility had 8 hours of RN coverage. After 8/16/24 the facility would use an audit tool weekly for 8 weeks. The DON applied for an RN waiver as of 8/14/24. The QA / Quality Assurance Performance Improvement (QAPI) meeting minutes dated 8/16/24 listed the facility census as 30 residents with 51 staff. The staffing section reflected the facility had 51 staff and they had flyers hung up to recruit. The August 2024 Quality Improvement Plan of Action forms lacked a plan regarding nursing staff. The QA / QAPI meeting minutes dated 9/9/24 indicated the facility's census as 31 residents with 55 staff. The section labeled Old Business reflected a review of the previous deficiencies progress. The documentation lacked documentation related to the nursing staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 25854 Based on observation, clinical record review, staff interview and equipment invoices, the facility failed to maintain patient care equipment in safe operating condition. The facility identified a census of 28 residents. Findings include: 1. Resident #2's clinical record reflected he had a code status (what to do in an emergency when resident's heart rate stops) of do not resuscitate (DNR). The Call Summary Report dated 11/14/24 included a call remark at 9:57 AM that indicated Resident #2 choked on peanut butter and the suction didn't work. The Health Status Note dated 11/14/24 at 10:00 AM reflected the writer got a call to go to the living room stat (immediately). When they arrived the found Resident #2 blue and purple with his eyes rolled back into his as he tried to gasp for air. When the Heimlich didn't work, the writer tried to suction his throat, sweeping it clean with their pointer finger. Staff D, assisted after her morning meeting with trying to get the suction machine to work. Then, Staff F, Maintenance, worked on the suction machine to find why it wouldn't work. The Health Status Note dated 11/14/24 at 10:53 AM indicated the staff observed Resident #2 in the communal area (living room) eating peanut butter crackers, when he started to choke. The staff performed finger sweeps and attempted to suction in order to dislodge the peanut butter crackers without success. On 1/17/25 at 4:00 PM Staff D reported the suction machine didn't function when a resident choked, but the staff responded appropriately. 2. An undated typed statement written by Staff D, Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON), they indicated Resident #1 was drowning in her aspirations (inhaled secretions into the lungs) and the suction machine didn't work properly. When the nurse consultant investigated the suction machine, she determined the machine had the wrong canister used and it couldn't create a suction. The staff received education and the facility corrected the issue. According to an invoice from the facility's equipment provider dated 11/14/24 the facility purchased new plastic suction canisters for their suction machine.