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	04/22/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on clinical record review and staff interview, the facility failed to ensure one of 3 residents (Resident #2) remained free from a medication error, failed to document the error in the clinical record, and failed to follow professional standards for reconciling controlled drugs (medications with a high potential for abuse). The facility reported a census of 23 residents. Findings include:Resident #2's quarterly 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 Parkinson's disease (brain disorder), depression, and sleep apnea (breathing stops during sleep). The MDS documented he received an antianxiety medication (medication used to treat anxiety) during the 7-day lookback period.On 4/20/26 at 1:58 PM, observed Staff C, Certified Medication Aide (CMA), and Staff D, CMA, performing the controlled drug count for the shift change. Staff C looked at the bubble packs for the controlled drugs and Staff D read the count off the controlled drug sheets in the binder. Staff C didn't compare the bubble pack to the sheet to ensure it was the right resident, medication, and correct count. Staff E, Licensed Practical Nurse (LPN), stood to the side of the cart observing the count next to Staff D. At 2:00 PM, when they finished the count finished, all three staff reported this as the normal process for counting controlled drugs.On 4/20/26 at 2:03 PM, the Director of Nursing (DON) reported that a staff member who just finished the controlled drug count reported they completed the count incorrectly. The DON reported staff didn't compare the bubble pack to the sheet to verify the correct drug, count, and resident. The DON reported she verbally educated the staff and planned to provide written education.Review of the facility reported incident investigation for missing controlled drugs on 10/31/25 documented Staff A, LPN, didn't sign the controlled drugs out at the time of giving the medication. The report documented Staff A gave Resident #2 a double dose of lorazepam (antianxiety medication). Resident #2 was missing another dose of lorazepam that was unaccounted for on 10/31/25. The facility's 5-day investigation documented Staff B, Registered Nurse (RN), was noted on video footage on 10/30/25 at 11:07 PM performing the controlled drug count. At 11:08 PM, Staff B punched out Resident #2's lorazepam and taped it into another resident's-controlled drug card. The investigation documented the staff's inaccurate reconciliation (matching records to actual supply) and count at shift change.Resident #2's Electronic Health Record (EHR) lacked documentation of the medication error in the chart. The chart lacked the controlled drug count sheet for October 2025 through November 2025 for the lorazepam.During an interview on 4/21/26 at 11:20 AM, the Administrator reported the controlled drug sheet for Resident #2's lorazepam during the medication discrepancy was missing. The Administrator reported staff have looked for it since the investigation but can't find it.During an interview on 4/21/26 at 12:15 PM, Staff A reported Staff F, CMA, performed the controlled drug count in the morning with Staff B. Staff A reported she didn't sign the controlled drugs out when she gave the medication. Staff A reported she went back later to sign them out and thought she didn't give Resident #2 his medication, so she gave him a dose around 8:00 PM. Staff A reported when she signed the book later, she realized she gave him another dose by mistake. Staff A reported she notified the physician (doctor). Staff A reported later when doing a count with Staff B, (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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	165438	A. Building B. Wing	04/22/2026

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she noticed the controlled drug discrepancy.On 4/22/26 at 8:51 AM, the DON reported she couldn't find anything in the EHR documenting Resident #2's medication error and stated it should've been in the record.The undated Controlled Substances policy directed staff to reconcile controlled drugs upon receipt, administration, disposal, and at the end of each shift.The undated Medication Error-Incident Report Process policy directed staff that a medication error must be documented in the resident records and a medication error form must be filled out.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure one of one residents (Resident #2) remained free from a medication error and failed to document the error in the clinical record. The facility reported a census of 23 residents. Findings include:Resident #2'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 Parkinson's disease (Brain disorder causing tremors, stiffness, and difficulty with movement), depression, and sleep apnea (A condition where breathing repeatedly stops and starts during sleep). The MDS documented he received an antianxiety medication during the 7-day lookback period. Review of the facility reported incident investigation for missing controlled drugs on 10/31/25 documented Staff A, Licensed Practical Nurse (LPN), didn't sign the controlled drugs record at the time of giving the controlled drug medication to ensure accurate documentation. The report documented Staff A gave Resident #2 a double the dose of lorazepam (an antianxiety medication). Resident #2's Electronic Health Record (EHR) lacked documentation of the medication error assessment and follow-up in the chart.On 4/21/26 at 12:15 PM, Staff A, Registered Nurse (RN) reported Staff F, Certified Medication Aide (CMA) performed the controlled drug (medications with a high potential for abuse) count in the morning with Staff B, RN. Staff A reported she didn't sign the controlled drugs out when she gave the medication later that day. Staff A reported she went back later to sign the medication out as given and thought she didn't give Resident #2 his medication. Staff A then gave Resident #2 another dose around 8:00 PM. Staff A reported when she signed the book later, she realized she gave him another one by mistake. Staff A reported she notified the physician (doctor). Staff A reported later when doing a count with Staff B that she noticed the controlled drug discrepancy.On 4/22/26 at 8:51 AM, the Director of Nursing (DON) reported she couldn't find any information in the EHR documenting Resident #2's medication error, assessment, or follow-up in the chart and stated it should be there.The undated Medication Error-Incident Report Process policy directed staff a medication error must be documented in the resident records and to monitor for any adverse effects (unwanted or harmful results) caused by the error.