

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Stacyville Community Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003</p> <p>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.</p> <p>Findings include:</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Resident #20's June 2024 Medications Administration Record (MAR) reflected they received morphine (an opioid drug) during the look back period.</p> <p>During an interview on 7/16/24 at 4:37 PM, the Interim DON reported they should code Morphine on the MDS.</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 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/17/24 at 11:56 AM, the Administrator reported they should code Morphine on the MDS.</p> <p>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.</p> <p>Resident #29's June 2024 MAR indicated they received Eliquis (anticoagulant medication) during the look back period.</p> <p>During an interview on 7/16/24 at 4:36 PM, the DON reported they should code Eliquis on the MDS.</p> <p>During an interview on 7/17/24 at 11:51 AM, the Administrator reported they should code Eliquis on the MDS.</p> <p>41537</p> <p>4. Resident #3's MDS assessment dated [DATE] indicated they used bed rail restraints daily during the seven day look back period.</p> <p>The Care Plan Focus revised 3/25/24 indicated Resident #3 used physical restraint bed rails.</p> <p>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.</p> <p>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.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537</p> <p>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.</p> <p>Findings include:</p> <p>Resident #11's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of depression and psychotic disorder.</p> <p>Resident #11's Medical Diagnoses reviewed on 7/16/24 listed the following diagnoses:</p> <ul style="list-style-type: none"> a. 7/28/21 - Major depression disorder b. 2/22/22 - Unspecified psychosis not due to a substance or known physiological condition <p>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.</p> <p>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.</p> <p>The facility provided an untitled policy dated 2023 that lacked instruction on when to submit new mental health diagnoses for PASRR review.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003</p> <p>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.</p> <p>Finding include:</p> <p>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).</p> <p>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.</p> <p>During an interview on 7/16/24 at 4:50 PM, the Interim DON reported his Care Plan should include bed rails.</p> <p>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</p> <p>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.</p> <p>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.</p> <p>On 7/24/24 at 2:33 PM observed Resident #25 with a urinary catheter.</p> <p>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.</p> <p>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.</p> <p>41537</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>Review of Resident #28 current Care Plan on 7/16/24 lacked interventions specific to her care and treatment needs.</p> <p>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.</p> <p>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.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537</p> <p>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.</p> <p>Findings include:</p> <p>Resident #11's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of depression and psychotic disorder.</p> <p>Resident #11's Medical Diagnoses reviewed on 7/16/24 listed the following diagnoses:</p> <ul style="list-style-type: none"> a. 7/28/21 - Major depression disorder b. 2/22/22 - Unspecified psychosis not due to a substance or known physiological condition <p>Resident #11's Current Care Plan reviewed on 7/15/24 lacked instruction and interventions related to his major depression disorder and psychosis.</p> <p>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.</p>

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The Care Plan reviewed on 7/16/24 lacked a comprehensive review and interventions for her to discharge to another facility.</p> <p>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.</p> <p>The Deaths/Discharges policy, dated 2023, lacked instruction to staff on how to incorporate residents wishes and goals to discharge home.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>48003</p> <p>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.</p> <p>Finding include:</p> <p>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.</p> <p>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.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537</p> <p>Based on record review and staff interviews the facility failed to ensure 1 of 1 resident (Resident #28) received an anti psychotic medication (Olanzapine) for only the diagnoses related to psychiatric/mood disorders upon admission. The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>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. The MDS lacked documentation of psychiatric or mood disorders.</p> <p>The Order Note dated 6/23/24 at 7:36 PM reflected an order for olanzapine in the evening related to dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>The History and Physical (H&P) dated 6/12/24 lacked documentation that Resident #28 received an antipsychotic medication at home prior to her hospitalization on [DATE].</p> <p>Resident #28's Clinic Nursing Home Note, dated 6/13/24, identified her provider instructed, he would have her continue on olanzapine, but with a goal to try to wean her down over time.</p> <p>Resident #28 current Care Plan on 7/16/24 lacked a comprehensive review and interventions for goals and interventions for use of anti psychotic medication.</p> <p>During an interview on 7/16/24 at 4:14 PM the Director of Nursing (DON) reported she didn't know Resident #28 received an anti psychotic medication for dementia and didn't take it prior to her admission to the facility.</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>An untitled statement, dated 4/11/24 reflected on 4/11/24, Resident #1 received another resident's medications consisting of:</p> <ul style="list-style-type: none"> a. Benzotropine 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) <p>Resident #1, Medication Review Report dated 4/8/24 indicated he didn't take the following medications:</p> <ul style="list-style-type: none"> a. Benzotropine mesylate 0.5 mg b. Atorvastatin 40 mg c. Clozapine 300 mg d. Cranberry 500 mg g. Sertraline 150 mg <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Record review of Resident #1 MDS log in his Electronic Health Record (EHR) informed he discharged on [DATE] and returned on 4/14/24.</p> <p>Record review of Resident #1 Discharge Summary from the local hospital dated 4/14/24 documented discharge diagnoses of:</p> <ul style="list-style-type: none"> a. Acute COVID infection b. Inadvertent dose of antipsychotic medication, patient given dosing error causing a fair amount of sedation <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Stacyville Community Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 413 South Broad Street Stacyville, IA 50476	
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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> a. Right medication b. Right dose c. Right time d. Right route e. Right resident 		

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<p>F 0851</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>48003</p> <p>Based on nursing time card review and staff interview, the facility failed to accurately report the Payroll Based Journal (PBJ) for licensed nursing staff during the second quarter of fiscal year 2024. The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>Review of the PBJ report provided by the Centers for Medicare and Medicaid Services (CMS) for Fiscal year 2024 second quarter, indicated the facility didn't have licensed nurse coverage 24 hours a day, seven days a week.</p> <p>The second quarter 2024 Nursing Timecards reflected the facility had licensed nurse coverage 24 hours a day, seven days a week.</p> <p>During an interview on 7/16/24 at 1:30 PM, the Administrator reported she submitted the PBJ wrong for the 24-hour nursing coverage. She reported the facility did have 24 hours a day, seven days a week nursing coverage.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003</p> <p>Based on observations, staff interviews, the Centers for Medicare and Medicaid Services (CMS), and the Assure Prism Manual, the facility failed to adequately sanitize the blood sugar meter and use barrier when doing blood sugar checks and insulin for 3 of 3 residents reviewed (Resident #25, #10, and #26). The facility reported a census of 31.</p> <p>Findings include:</p> <p>1. Resident #25's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS included a diagnosis of diabetes. The MDS listed Resident #25 received insulin injections.</p> <p>During an observation on 7/16/24 at 8:05 AM, Staff B, Certified Medication Aide reported she planned to check Resident #25's blood sugar. Staff B performed hand hygiene, gathered the Assure Prism blood sugar meter (a device used to measure the concentration of glucose in the blood, typically using a small drop of blood placed on a disposable test strip) supplies, and went to the dining table. Staff B set the supplies down on the table, cleansed Resident #25's finger with alcohol and poked their finger with the lancet (device with a needle to collect the blood drop). Staff B set the lancet on the table, picked up the meter, and got the blood on the test strip. Staff B set the meter back down on the table and gathered her supplies. After Staff B finished the blood sugar check, they returned the meter to the medication cart. Staff B placed the blood sugar meter in the plastic basket without cleaning the meter.</p> <p>During an interview on 7/16/24 11:35 AM, Staff A, Registered Nurse (RN), reported the staff need to clean the blood sugar machines between each resident and have a barrier under the supplies.</p> <p>On 7/16/24 at 11:38 AM the Interim Director of Nursing (DON) reported the staff should clean the Accu Chek machines between each resident.</p> <p>2. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS included a diagnosis of diabetes. The MDS listed Resident #10 received insulin injections.</p> <p>During an observation on 7/16/24 at 8:10 AM, Staff C, RN, reported she planned to check Resident #10's blood sugar and give him insulin. Staff C performed hand hygiene, gathered the Assure Prims blood sugar meter, insulin and supplies. Staff A went to Resident #10's room set blood sugar supplies on a Kleenex and insulin down on the bedside table. Staff A cleaned Resident #10's finger with alcohol, then poked their finger with the lancet. Staff C set the lancet on the Kleenex, picked up the meter, and got the blood on the test strip. Staff C set the meter down on the table, picked up the insulin, an alcohol wipe, and cleaned the site with the alcohol wipe, then gave Resident #10 insulin. After Staff C finished, she gathered her supplies and returned to the medication cart. Staff C placed the blood sugar meter in a plastic basket without cleaning it and put the insulin back in the cart in Resident #10's bin.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Resident #26's MDS assessment dated [DATE] identified they had modified independence for cognition. The MDS included a diagnosis of diabetes. The MDS listed Resident #26 received insulin.</p> <p>During an observation on 7/16/24 at 8:35 AM, Staff C, Registered Nurse (RN) reported she planned to check Resident #26's blood sugar and give her insulin. Staff C performed hand hygiene, gathered the Assure Prims blood sugar meter, insulin, and supplies. Staff C went to Resident #26 in the dining room, set the blood sugar supplies, and insulin down on the table. Staff C cleansed Resident #26's finger with alcohol and poked the finger with the lancet. Staff C set the lancet on the Kleenex, picked up the meter, and got the blood on the test strip. Staff C set the meter down on the Kleenex, picked up the insulin, an alcohol wipe, and cleaned the site with the alcohol wipe. Staff C gave Resident #26 insulin and the insulin pen on a different dining table next to Resident #26's dining table, where another resident sat. After Staff C finished, she gathered her supplies and returned to the medication cart. Staff C placed the blood sugar meter in the plastic basket without cleaning it and put the insulin back in the cart in Resident #26's bin.</p> <p>The Assure Prism Glucose Manufacturer's Quality Assurance/ Quality Control Reference Manual revised April 2015 directed the following:</p> <p>a. Before performing a blood glucose test, observe the following safety precautions:</p> <ul style="list-style-type: none"> i. Consider all components that come into contact with blood samples biohazardous capable of transmitting viral diseases between patients and healthcare professionals. ii. Before testing each patient, the nurse should wear a new pair of clean gloves. iii. Wash hands thoroughly with soap and water before putting on the new pair of gloves and performing the next patient's test. iv. Use only an auto disabling, single use lancing device for each patient. After use on each patient, clean and disinfect the meter. <p>b. Cleaning and disinfecting the meter to minimize the risk of transmitting blood borne pathogens. The staff should clean and disinfect as recommended in the instructions. The staff should clean and disinfect the meter after use on each patient. The Assure Prism Multi-Blood Glucose Monitoring System may only use the meter to test multiple patients when following the standard precautions and manufacturer's disinfection procedures. The staff must follow the cleaning procedure to clean dirt, blood, and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The meter needed the disinfection procedure to prevent the transmission of blood borne pathogens. The meter had a variety of the most commonly used EPA registered wipes tested and approved for cleaning and disinfecting of the Assure Prism Multi-Blood Glucose Monitoring System.</p> <p>c. Cleaning:</p> <ul style="list-style-type: none"> i. Step 1: Wear appropriate protective gear such as disposable gloves. ii. Step 2: Open the towelette container, pull out 1 towelette, and close the lid. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>iii. Step 3: Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using 1 towelette to clean blood and other body fluids.</p> <p>iv. Step 4: Dispose of the used towelette in a trash bin.</p> <p>d. Disinfecting (The staff must clean the meter prior to disinfection.):</p> <p>i. Step 5: Open the towelette container, pull out 1 towelette, and close the lid.</p> <p>ii. Step 6: Wipe the entire surface of the meter 3 times horizontally and 3 times vertically to remove blood borne pathogens.</p> <p>iii. Step 7: Dispose of the used towelette in a trash bin.</p> <p>iv. Step 8: Allow exteriors to remain wet for the appropriate contact time and then wipe the meter using a dry cloth.</p> <p>v. Step 9: After disinfection, the user should remove, throw away their gloves, and wash their hands before proceeding to the next patient.</p> <p>The Injection Safety related to Infection Prevention during Blood Glucose Monitoring and Insulin Administration summary reviewed 3/2/11 indicated CDC became concerned about the risks for transmitting hepatitis B virus (HBV a serious liver infection) and other infectious diseases during assisted blood glucose (blood sugar) monitoring and insulin administration. The CDC alerted all persons who assist others with blood glucose monitoring and/or insulin administration of the following infection control requirements:</p> <p>a. Never use a fingerstick device for more than one person</p> <p>b. Whenever possible, don't share the blood glucose meters. If the facility must share the meter, they should clean and disinfect the device after every use, per the manufacturer's instructions.</p> <p>Unsafe practices during assisted monitoring of blood glucose and insulin administration that have contributed to transmission of HBV or have put persons at risk for infection include:</p> <p>a. Using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses.</p> <p>Blood glucose meters are devices that measure blood glucose levels.</p> <p>a. Whenever possible, assign blood glucose meters to an individual person and not share.</p> <p>b. If unable to not share blood glucose meters, the user must clean and disinfect the device after every use, per manufacturer's instructions, to prevent carry over of blood and infectious agents. If the manufacturer didn't specify how they should clean and disinfect the device then they shouldn't share.</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>48003</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>During an interview on 7/16/24 at 11:34 AM Staff A reported she took the class but didn't complete the test.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>41537</p> <p>Based on record review, staff interviews, and policy review the facility failed to have a system in place for residents to decline vaccinations if desired for 3 of 4 residents (Resident #16, #5, and #20). The facility reported a census of 31 residents.</p> <p>Findings include:</p> <p>Resident #16's Immunization History reflected he received his last Influenza vaccine on 10/22/21.</p> <p>Resident #5's Immunization History identified he never received an influenza vaccine.</p> <p>Resident #20's Immunization History indicated they received their last Influenza vaccine on 11/26/12.</p> <p>During an email correspondence on 7/17/24 at 11:14 AM the Administrator reported the Infection Preventionist (IP) didn't get written documentation showing she educated Residents #16, #5, and #20 about the risks and benefits of the Influenza vaccine. In addition, the IP didn't document their choice to receive or decline the Influenza vaccine.</p> <p>The Influenza Vaccine Program directed the documentation in the resident's medical record will include:</p> <p>a. The resident or the resident's representative received education regarding the benefits and potential side effects of the influenza vaccine.</p> <p>b. The resident received the influenza vaccine or the resident didn't receive the influenza vaccine and the reason why.</p>