

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Winslow House Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3456 Indian Creek Road Marion, IA 52302	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19126</p> <p>Based on observation, staff and resident interviews, and facility policy and clinical record review, the facility failed to ensure an accurate inventory of medications by accounting for controlled medications that have been received, dispensed, and administered for four of four residents reviewed. (Residents #1, #5, #6, & #7). The facility reported a census of 44 residents.</p> <p>Findings include:</p> <p>1. The MDS (Minimum Data Set) dated 2/5/2025 revealed Resident #1 had intact cognitive skills, transferred with assistance, had diagnoses including diabetes, chronic pain, and heart disease. The MDS indicated the resident had frequent pain rated at #8 on a scale of 1-10. The Care Plan identified the resident had pain and directed staff to administer medications as ordered and assess effectiveness.</p> <p>The physician's order's included an order for Hydrocodone-Acetaminophen Tablet 5-325 mg (milligrams). Give one tablet by mouth every 12 hours as needed for pain dated 12/11/2024. On 12/26/2024 the physician changed the order and instructed staff to administer one tablet every 8 hours. On 1/31/2025, the physician changed the order and directed staff to administer the medication every 4 hours as needed and 1 tablet scheduled at bedtime.</p> <p>A review of the resident's December, 2024 MAR (Medication Administration Record) and the Controlled Substance Shift Count and Usage Record revealed:</p> <p>12/12/2024 and 12/23/2024, staff signed off Hydrocodone-Acetaminophen 5-325 mg tablets on the count sheet and failed to document the medication administration on the resident's MAR.</p> <p>1/1/2025 - 1/31/2025, staff signed off the Hydrocodone-Acetaminophen 5-325 mg tablets on 1/6 (two times), 1/7, 1/9, 1/12, 1/14, 1/15, 1/18, 1/19, 1/20, 1/23. The count sheet indicated staff dropped the medication on 1/15/2025.</p> <p>On 3/31/2025 at 12:30 P.M. the resident voiced no concerns with his medications and currently found relief with Tramadol, a recent physician order.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/24/2025 the facility self reported to the Department of Inspections and Appeals a concern with Resident #1's Hydrocodone/Acetaminophen. On 1/23/2025 Staff E, Medication Aide identified the resident's medication cassette, the plastic tab that enclosed the medication in the cassette appeared loose and the Hydrocodone/Acetaminophen had been replaced with a Tylenol. The facility followed up with an investigation and reported it to police.</p> <p>The MDS dated [DATE] revealed Resident #5 had intact cognitive skills, had diagnoses including Parkinson's disease and breast cancer, and had constant pain rated as high as #10 on a scale of 1-10. The Care Plan identified the resident had back pain and directed staff to administer medications as ordered and assess the pain and effectiveness.</p> <p>The physician's orders included:</p> <p>Oxycodone 5 mg, every evening at bedtime started on 4/11/2024.</p> <p>Oxycontin ER 10 mg every 12 hours for pain started on 2/23/2025 and discontinued on 3/6/2025.</p> <p>Oxycodone 5 mg every 8 hours as needed for pain started on 3/20/2023.</p> <p>The Usage Record revealed:</p> <p>Oxycodone 5 mg, staff signed off on the count sheet on 1/17/2025 and failed to document the medication administration on the resident's MAR.</p> <p>The facility failed to provide the entire Controlled Substance Shift Count and Usage Records for Oxycodone 5 mg initiated on 1/21/2025 with 30 doses on hand through 1/31/2025 with 39 doses remaining. On 1/28/2025 the count sheet added 29 doses delivered from the pharmacy on 1/28/2025</p> <p>The facility failed to provide the entire Controlled Substance Shift Count and Usage Records for Oxycontin ER 10 mg initiated on 11/17/2024 with 28 doses on hand through 11/22/24 with 13 doses remaining.</p> <p>The MDS dated [DATE] revealed Resident #6 had moderately impaired cognitive skills, diagnoses including dementia and scoliosis, and had frequent pain that affected sleep. The Care Plan identified the resident had pain related to scoliosis and directed staff to administer medications as ordered, assess the effectiveness and monitor signs of pain.</p> <p>The physician orders included an order for Hydrocodone-Acetaminophen 7.5 - 325 mg/15 ml (milliliters). Give 15 ml by mouth every 8 hours as needed.</p> <p>The facility failed to provide complete records of Hydrocodone/Acetaminophen 7.5/325 mg. administration and count sheets for pharmacy deliveries dated:</p> <p>11/20/2024 - #45 doses</p> <p>11/22/2024 - #473 doses</p> <p>12/16/2024 - #90 doses</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1/10/2025 - #100 doses</p> <p>1/15/2025 - #73 doses</p> <p>2/11/2025 - #473 doses</p> <p>A review of the resident's medication administration records, count sheets and pharmacy delivery sheets revealed incomplete documentation and verification.</p> <p>On 4/1/2025 at 1:15 P.M. the resident sat on the edge of her bed and indicated she often had pain in her legs, and took Lortab (Hydrocodone/Acetaminophen) one or two times a day.</p> <p>The MDS dated [DATE] revealed Resident #7 had severe cognitive impairment, diagnoses including spinal stenosis and diabetes, and received scheduled and as needed pain medication. The Care Plan indicated the resident had pain related to spinal stenosis and received opioid and non opioid medications. The Care Plan directed staff to administer medications as ordered, assess the effectiveness and monitor complaints of pain.</p> <p>They physician's orders included:</p> <p>Morphine 20 mg/ml, 5 mg every 4 hours as needed (0.25 ml). 1/16 - 1/17/2025. 1/17/2025 - new physician order - Give 0.5 ml every 4 hours as needed.</p> <p>12/6/20204 - Fentanyl patch every 72 hours - 12 mcg (micrograms)/hour.</p> <p>Oxycodone 5 mg, one tablet every 4 hours as needed. 1/10- 1/17/2025</p> <p>Oxycodone 10 mg - one tablet every 4 hours for pain. 1/10 - 1/17/2025.</p> <p>Hydromorphone 2 mg, one tablet every 6 hours as needed. 1/3- 1/10/2025.</p> <p>Fentanyl patch every 72 hours - 50 mcg/hour. 1/16 - 1/19/2025.</p> <p>Hydrocodone/Acetaminophen 10/325 mg., 1 tablet every 4 hours as needed. 11/8/2024.</p> <p>The Usage Record revealed staff signed off on the count sheet doses of the Hydrocodone/Acetaminophen 10/325 mg 2 doses on 12/11, 2 doses on 12/12, 1 dose on 12/17, and 1 dose on 12/18. Staff failed to sign off administration of the medication on the December MAR.</p> <p>The pharmacy delivery records included:</p> <p>#30 Hydrocodone/APAP 10 -325 mg delivered on 11/19/2024, 11/25/2024 and 12/3/2024. The facility failed to provide the Controlled Substances Shift Count and Usage Records to verify administration and accounting of the medication.</p> <p>2. Observation on 4/1/2025 at 12:22 PM of a narcotic drug count for medication carts South and North/Northwest with Staff A-RN and Staff B-RN revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. At 12:25 PM a bubble pack for Resident #8 labeled Hydro/APAP tab 5-325 milligrams to take 1 tablet by mouth 3 times a day laid on top of the cart empty. Review of the Controlled Drug Receipt record revealed there should have been 2 tablets remaining in the card. Interview with Staff A-RN at this time revealed Staff A gave the resident a dose of Hydro/APAP at 7 am and 1130 am but failed to sign the medication out this am after she administered the medication to the resident. Staff A-RN signed off the 2 narcotic tablets at this time that she gave earlier today.</p> <p>b. At 12:35 PM a bubble pack for Resident #1 revealed 36 Tramadol HCL tabs 50 milligrams to take 1 tablet by mouth 3 times daily. The Tramadol bubble pack revealed 36 Tramadol tablets but the Controlled Drug Receipt Record indicated there should be 37 Tramadol tablets. Staff A-RN stated she gave Resident #1 a Tramadol at 8:00 am today but failed to sign it out on the receipt record. Staff A signed off the narcotic at this time.</p> <p>During an interview on 4/1/25 at 1:00 PM with Staff C-Administrator, Staff C stated she would expect the nurses to sign out the narcotics at the time they dispense them.</p> <p>On 3/31/2024 at 12:35 P.M., Staff F, DON (Director of Nursing) reported working at the facility for one year. Staff E phoned Staff F on 1/23/2025 and reported the concern with Resident #1's Lortab (Hydrocodone/Acetaminophen). The Lortab had a Tylenol in the cassette in it's place. Staff F directed Staff E not to give it, and to give his Lortab. The investigation went from there. They reviewed the resident's pain, and he had no increase in pain, he felt he was getting the right medication and had no concerns. Staff reviewed all cassettes to ensure the medications were correct, and they found no further issues. A narcotic count on all residents failed to reveal any concerns. Nursing staff were re-educated regarding medication administration and narcotic counts. We also followed up with education regarding what a med aide's scope of practice is. Some of the nurses received written disciplines/education regarding signing out the narcotics on the count sheets and also documentation on the MAR in PCC (Point Click Care). Staff F reported she continued with weekly audits to ensure staff document medication administration correctly. The facility received corporate direction to keep medication cart keys with the assigned nurse at all times during the shift. On 4/1 at 3:45 PM - Staff F reported they had no further information related to the narcotics, MARS and count sheets to submit.</p> <p>On 3/31 at 1:08 P.M., Staff A, RN reported working at the facility for two years and had no concerns with narcotic counts. Staff always count with two staff and verify information. Prior to this incident Staff A would hand the keys to her medication cart to another staff RN or DON if she took a lunch break and left the facility, and would not count narcotics prior to leaving. Currently, she keeps the keys with her when she leaves the building during her lunch break. They were told to. Staff A had no concerns with any staff, and they were all re-educated, and the facility now uses medication blister packs instead of the plastic cassettes. Staff destroy narcotics with two staff, and place the discontinued medications in the drug buster.</p> <p>On 3/31/2025 at 10:50 A.M., Staff D, RN reported working at the facility for 6 years. Staff D verified her initials on the January, 2025 Controlled Substance Shift Count and Usage Record for Resident #1.</p> <p>NARCOTIC COUNT AND USAGE RECORD compared to the January 2025 MAR with Staff D:</p> <p>January 1 - two doses signed out at 0700 and 1110. MAR - No 0700 dose on MAR</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>January 6 - two doses signed out at 0630 and 1200 - MAR - Neither dose on MAR</p> <p>January 9 - two doses signed out at 0700 and 1500 - MAR - Neither dose on MAR</p> <p>January 14 - dose signed out at 0800 - Not on MAR</p> <p>January 15 - 0800 dose dropped, one dose given at 0800 - Not on MAR</p> <p>January 19 - 0800 dose signed out at 0800 - Not on MAR</p> <p>January 20 - 0900 dose signed out at 0900 - Not on MAR</p> <p>Staff D indicated she must have forgotten to put in on the MAR.</p> <p>At 3:30 P.M. - Staff D reported on 1/15/2025 she dropped the Lortab as documented on the count sheet. She administered the medications while the resident sat in bed and she dropped the entire cup of his pills. She reported it to housekeeping and they swept and did not find it. Staff D received discipline for documentation errors, including education regarding signing out narcotics. Staff D revealed she used to give the medication cart keys to another nurse when she left the facility and went to lunch. About six weeks ago administration instructed staff to keep the keys on them at all times. Staff D still leaves, but she takes the keys with her. The keys in her possession include keys to the medication room, medication cart, and narcotic drawer.</p> <p>On 4/1/25 2:10 P.M. Staff E, Medication Aide, via phone interview reported working at the facility for four years. Staff E worked every weekend and 6-10 P.M. Monday through Friday. On 1/23/2025 Resident #1 asked for a PRN (as needed) pain medication . Staff E notified Staff H, RN the agency nurse on duty. He instructed Staff E to administer the PRN. When she attempted to open the cassette, the door appeared weak, and the pill did not look correct. It had the appearance of a Tylenol. Staff E reported the concern to Staff H, and notified the DON. The DON instructed her to fill out a form, lock up the medication and not to give it. The remaining pills in the cassette were correct. Currently, medication aides are allowed to count the narcotics along with a nurse at the change of shift. Pharmacy delivers medications during her shift, and both the nurse and medication aide can accept the medications, sign for them and place the delivery record in a folder in the medication room.</p> <p>Review of the undated Controlled Substance - Administration Steps procedure directed the staff to do the following:</p> <ol style="list-style-type: none"> 1. Medications listed as Schedule II are stored separately from all other medications. 2. The medication aide/nurse on duty maintains possession of the key to controlled storage area. 3. When a controlled substance is administered, the med aide/licensed nurse administering the medication immediately completes the usage record. 4. At shift change, a physical inventory of all schedule II medications is conducted by (2) licensed nurses/med aide. Inventory must be completed with both staff present. <p>(continued on next page)</p>		

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