| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 165455 | A. Building<br>B. Wing | 06/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Accura Healthcare of Carroll | 2241 North West Street<br>Carroll, IA 51401 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, resident interviews, facility documentation and policy review, the facility failed to provide care for 6 out of 15 residents reviewed (Resident #1,#6, #9, #11, #12, #2) in a manner to promote dignity and respect. The facility reported a census of 47 residents.<br><br>Findings include:<br><br>1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Staff Assessment for Mental Status indicating severely impaired cognition. The MDS identified Resident #1 was dependent on staff for eating. Resident #1's MDS included diagnoses of Alzheimer's disease, non-Alzheimer's dementia, and anxiety disorder.<br><br>On 6/18/25 at 9:37 AM, Staff B, Registered Nurse (RN) reported on 6/5/25 during breakfast she observed Resident #1 reached for his plate of food and saw Staff A, Certified Nursing Assistant (CNA) push his hands away. She said Resident #1 reached for the plate of food 3-4 more times and Staff A would swat his hands away. She said each time Staff A would get more and more aggressive with pushing his hands away. She said she was getting ready to intervene when she observed Staff A shove Resident #1's wheelchair away from the table and take him out to the common area.<br><br>2. Resident #6's MDS assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.<br><br>On 6/18/25 at 12:53 PM, Resident #6 reported Staff A, CNA did not have the best bedside manners. She said Staff A would come off like you were bothering her. She said she did not like to ask for help if she thought she was being bothersome. She said the other aides do not make her feel that way. She said you have to have a certain personality when working with people.<br><br>3. Resident #9's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition.<br><br>A facility form titled Resident Investigation Questionnaire dated 6/6/25 documented Resident #9 reported Staff A, CNA rushed through cares, left the room when she was trying to tell her something and has a bad attitude all the time. The form further documented Resident #9 had to wait long after lunch when Staff A worked to go to the bathroom.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 6/19/25 at 9:00 AM, Resident #9 reported she had a long call light over the weekend and it took forever for the staff to come. She said she thought her call light was on for an hour. She said she can not wait that long to go to the bathroom. She said she had an accident (urinated herself) and it made her feel terrible.<br><br>4. Resident #11's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition.<br><br>A facility form titled Resident Investigation Questionnaire dated 6/6/25 documented Resident #11 reported Staff A, CNA had a bad attitude and was a little rough.<br><br>On 6/18/25 at 12:40 PM, Resident #11 said Staff A, CNA was rude/harsh related to the tone of her voice and short tempered. Resident #11 reported Staff A had thrown her pillows and blankets on her, did not give her water when she asked for it, and didn't help her get off the toilet. Resident #11 stated she was left on the toilet for 20 minutes. Resident #11 said she felt her dignity was being ruined because of how Staff A treated her.<br><br>5. Resident #12's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition.<br><br>A facility form titled Resident Investigation Questionnaire dated 6/6/25 documented Resident #12 reported Staff A, CNA had a negative attitude, was quick with cares, needed to slow down and not rush people.<br><br>6. Resident #2's MDS assessment dated [DATE] identified a BIMS score of 9, indicating moderately impaired cognition.<br><br>On 6/23/25 at 3:22 PM, Hospice RN reported Resident #2 had mentioned concerns with one staff member in the past (Staff C,CNA) but had not mentioned anything in the last month. She said last week somebody had brought Resident #2's lunch tray to his room, did not set the tray up and he spilled some of the food while trying to eat. The Hospice RN reported Resident #2 told her that he was called an asshole because he spilled the food. The Hospice RN said she was not 100% sure which staff member was involved. She said when she left the facility she talked to one of the nurses and asked them to make sure his tray table was over him and set up so he could reach his food.<br><br>On 6/23/25 at 3:57 PM, the Hospice Social Worker reported she did not feel the staff were willing to go to Resident #2's room to help him quickly. She said the general tone of CNAs when answering Resident #2 was short and rude. She said hospice had made a suggestion of getting Resident #2 up for all meals so he had a change in scenery to help with his mood and depression. She said Staff C, CNA stated the 2 PM-10 PM shift did not have enough staff to get Resident #2 up so he would have to stay in bed unless he requested to get up. The Hospice Social Worker reported she felt Resident #2 and Staff C did not click and she thought it had to do with Staff C's demeanor and attitude.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 6/24/25 at 9:34 AM, Resident #2 reported Staff C and him go back and forth. He reported answering a question regarding Staff C put him in a tough place and that he did not want to have any retaliation from the staff. Resident #2 reported he just wanted to get along with Staff C. He reported a few days ago Staff C had raised her voice to him and he told her to get out of his room. He reported Staff C can get snippy and have an attitude at times. When asked what he meant by snippy, Resident #2 said Staff C had told him that he had pushed his call button too many times and that he did not appreciate that she had to take care of other people.<br><br>On 6/19/25 at 1:30 PM, [NAME], DON reported she expected the staff to treat residents with dignity and respect.<br><br>A facility policy titled Promoting/Maintaining Resident Dignity dated 1/30/24 documented it was the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to limit PRN (as needed) antipsychotic drugs to 14 days, failed to have a Physician evaluate for appropriateness of the medication and provide a clinical rationale prior to the antipsychotic medication usage being extended. In addition the facility failed to obtain a clinical rationale when an antianxiety medication usage was extended and also failed to complete behavioral documentation and offer/attempt nonpharmacological interventions prior to the administration of antianxiety medications for 1 out of 3 residents reviewed (Resident #2) for unnecessary medications. The facility reported a census of 47 residents.<br><br>Findings include:<br><br>Resident #2'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 identified Resident #2 as dependent on staff for bed mobility and chair/bed to chair transfers. Resident #2's MDS included diagnoses of anemia (low blood iron levels), hypertension (high blood pressure), diabetes mellitus, Alzheimer's disease, cerebrovascular accident (stroke), anxiety disorder, depression, respiratory failure and chronic lung disease. The MDS documented Resident #2 had received anti-anxiety medication in the last 7 days.<br><br>The Care Plan with a target date of 6/25/25 documented Resident #2 was at risk for adverse effects from routine/PRN use of anxiety/antidepressant medications due to diagnosis of depression and dementia with other behavioral disturbances. The Care Plan directed staff to monitor and document for targeted behavior symptoms such as verbal/physical aggression and nonpharmacological interventions such as offering food/fluids, toileting, activities, assessing for pain, calling family, repositioning and providing 1:1. The Care Plan directed to review medication as necessary, observe for effectiveness of the medications and report significant side effects to the Physician.<br><br>Review of the clinical record revealed Resident #2 was admitted to an inpatient hospital behavioral health unit on 8/15/24 and returned to the facility on 8/20/24.<br><br>A Physician Order dated 8/25/24 directed staff to administer Haloperidol (Haldol) (antipsychotic medication) 1 mg (milligram) by mouth every 4 hours PRN for behaviors.<br><br>A Physician Order dated 8/26/24 directed staff to administer Zyprexa 5 mg one tablet every fours as needed for anxiety/irritability and to continue the PRN medication for 6 months related to unpredictable behaviors associated with mental illness.<br><br>The Pharmacy Consulting Report dated 8/27/25 recommended assessing the PRN antipsychotic, Haloperidol. The form documented federal regulation requires that all PRN antipsychotic medication, regardless of indication be limited to 14 days. If a resident needs a PRN antipsychotic beyond 14 days, the patient has to be assessed and a new order to be written every 14 days. The Physician commented on 8/28/24 to continue the Haloperidol medication for 30 days. The clinical record lacked documentation of a physician assessment and a clinical rationale for the extended usage.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Pharmacy Consulting Report dated 8/27/25 recommended assessing the PRN antipsychotic, Olanzapine (Zyprexa). The form documented federal regulation requires that all PRN antipsychotic medication, regardless of indication be limited to 14 days. If a resident needs a PRN Antipsychotic beyond 14 days, the patient has to be assessed and a new order to be written every 14 days. The Physician documented on 10/23/24 on the consultation report that she ordered the Zyprexa for 6 months and to see rationale in the last refill.<br><br>Review of August 2024 Medication Administration Record (MAR) revealed Resident #2 received PRN Haloperidol 8 times between 8/25 to 8/31 and PRN Zyprexa 2 times from 8/26 to 8/31.<br><br>A Physician Order dated 9/10/24 directed staff to administer ativan injection solution (antianxiety medication) 2 mg/ml (milligrams/milliliter) 2 mg intramuscularly (IM) every 12 hours as needed for aggressive behaviors. Review of the clinical record revealed the physician order for PRN ativan IM was active from 9/10 to 1/20/24. The clinical record lacked a physician order and/or clinical rationale for the extended use after 14 days. Review of September 2024 to January 2025 revealed the PRN ativan injection was given 4 times in September, 8 times in October, 1 time in November, and 1 time in December.<br><br>The Pharmacy Consulting Report dated 9/17/24 recommended reassessing the PRN antipsychotic, Haloperidol due to the Physician response on 8/28/24. The Physician marked agree to limit the antipsychotic medication to 14 days on 9/25/24.<br><br>Review of September 2024 MAR revealed Resident #2 received PRN Haloperidol 55 times and PRN Zyprexa 15 times.<br><br>A Physician order dated 10/10/24 directed staff to continue the PRN Haloperidol 1 mg for 30 days. The clinical record lacked a physician assessment or clinical rationale for the extended usage.<br><br>Review of October 2024 MAR revealed Resident #2 received PRN Haloperidol 41 times and PRN Zyprexa 25 times.<br><br>A Physician Order dated 11/7/24 directed staff to continue the PRN Haloperidol 1 mg for 30 days. The clinical record lacked a physician assessment or clinical rationale for the extended usage.<br><br>Review of November 2024 MAR revealed Resident #2 received PRN Haloperidol 17 times and PRN Zyprexa 11 times.<br><br>The Pharmacy Consulting Report dated 10/23/24 recommended assessing the PRN antipsychotic, Haloperidol 1 mg every 4 hours PRN and Olanzapine (Zyprexa) 5 mg every 4 hour PRN. The form documented federal regulation requires that all PRN antipsychotic medication, regardless of indication be limited to 14 days. If a resident needs a PRN Antipsychotic beyond 14 days, the patient has to be assessed and a new order to be written every 14 days. In addition, the form documented Resident #2 MAR reflected using both medications on most days, sometimes more than one dose per day. The ARNP documented on the form on 12/10/24 to continue Zyprexa 5 mg every 4 hours PRN for agitation for 14 days. The ARNP did not provide a clinical rationale on the extended usage for the Zyprexa and did not address the Haloperidol in the note.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Physician Order dated 12/6/24 directed staff to continue the PRN Haloperidol 1 mg for 30 days. The clinical record lacked a physician assessment or clinical rationale for the extended usage.<br><br>Review of the clinical record revealed Resident #2 was admitted to Hospice services on 12/24/25 due to Alzheimer's disease.<br><br>A Physician Order dated 12/24/24 directed staff to continue the PRN Zyprexa 5 mg for 14 days. The clinical record lacked a physician assessment or clinical rationale for the extended usage.<br><br>Review of the December MAR revealed Resident #2 received PRN Haloperidol 11 times and PRN Zyprexa 9 times.<br><br>A Physician Order dated 1/6/25 directed staff to continue the PRN Zyprexa 5 mg for 30 days. The clinical record lacked a physician assessment or clinical rationale for the extended usage.<br><br>Review of January 2025 MAR revealed Resident #2 received PRN Zyprexa 1 time.<br><br>A Progress Note on 1/20/25 at 11:08 AM revealed Resident #2 had a decline in condition and that he was not verbally communicating with the staff. The note documented the primary care physician was notified of the change in condition.<br><br>A Progress Note on 1/20/25 at 11:59 AM documented verbal orders were received to discontinue all oral medications and to start morphine concentrate 0.25 ml every 2 hours as needed and ativan intensol 0.25 ml every 2 hours as needed.<br><br>A Progress Note on 1/23/25 documented new orders to increase ativan intensol to 0.5 ml every hour as needed for restlessness.<br><br>A Physician Order dated 4/2/25 documented to continue the ativan intensol 0.5 ml every 1 hour as needed for restlessness for 60 days. The clinical record lacked a clinical rationale for the extended usage.<br><br>The Pharmacy Consulting Report dated 5/27/25 for the PRN ativan intensol documented to continue the PRN medication for 60 days. The clinical record lacked a clinical rationale for the extended usage.<br><br>Review of June 2025 MAR from 6/1 to 6/22 revealed Resident #2 had received PRN ativan intensol 17 times. The June MAR documented no behaviors observed.<br><br>Review of the clinical record lacked any behavior documentation or nonpharmacological interventions attempted prior to the administration of the PRN Lorazepam from 6/1 to 6/22.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/24/25 at 1:00 PM, the DON reported she expected the staff to document behaviors and nonpharmacological interventions prior to the administration of a PRN psychotropic medication. She said she would expect staff to administer one PRN medication at a time and follow up on the effectiveness of the drug before giving additional medications. She said each drug works differently related to medication efficacy. The DON reported she expected the Physician to document a clinical rationale as to why the PRN psychotropic medications would need to be extended past 14 days. She reported both the PRN antipsychotic medications (Zyprexa and Haldol) should have been limited to 14 days and then reevaluated by the provider.<br><br>The facility policy titled Use of Psychotropic Medications revised 4/21/25 documented the intent of the policy was to ensure residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated. The policy further documented these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. The policy directed non-pharmacological approaches to be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications. The policy documented psychotropic medication used on a PRN basis must a a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and subject to limitations as noted:<br><br>a. PRN orders for psychotropic medication, excluding antipsychotic, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration.<br><br>B. PRN order for antipsychotic medications only, shall be limited to 14 days with no exceptions. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>Based on personnel file reviews, facility policy review and staff interviews, the facility failed to provide dependent adult abuse (DAA) recertification training within 3 years for 1 of 2 employees reviewed. The facility identified a census of 47 residents.<br><br>Findings include:<br><br>The personnel file for Staff A, Certified Nursing Assistant (CNA) documented a hire date of 5/15/24. Review of the Dependent Adult Abuse Mandatory Reporter Training Certificate documented Staff A completed the 2 hour dependent adult abuse training on 5/8/22.<br><br>The facility policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated 10/19/22 revealed each employee will be required to take a 1 hour recertification training within 3 years of the initial 2 hour training course and every three years thereafter.<br><br>On 6/17/25 at 11:40 AM, the Administrator reported Staff A did not have an updated DAA certificate. The Administrator stated she was not sure why Staff A had not taken the training. She said the facility had an excel spreadsheet to track the DAA training and Staff A was due for the training in May 2025.<br><br>On 6/19/25 at 1:30 PM, the Director of Nursing stated she expected staff to complete DAA training prior to the certificate expiring every three years. She said Staff A completed her training on 6/17/25. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on facility investigation review, staff interviews and policy review the facility failed to report an allegation of abuse within 2 hours to the Iowa Department of Inspections, Appeals and Licensing (DIAL) for 1 of 3 residents reviewed (Residents #1). The facility reported a census of 47 residents.<br><br>Findings include:<br><br>A facility form titled Self Report documented on 6/5/25 at 7:35 AM, Staff A, Certified Nursing Assistant was assisting Resident #1 eating his breakfast. During this time Staff B, Registered Nurse (RN), witnessed Staff A push Resident #1's hands away from his plate as he continued to grab towards it. Staff B stated this occurred multiple times before Staff A quickly wheeled Resident #1 away from the table prior to him completing his meal. The documentation revealed Staff B notified the Administrator regarding the allegations of abuse at approximately 3:30 PM on 6/5/25.<br><br>Review of the document titled Intake Information revealed the facility contacted the State Agency via phone regarding the allegation of abuse for Resident #1 on 6/5/25 at 4:57 PM and completed the online self report on 6/6/25 at 10:40 AM.<br><br>On 6/17/25 at 1:15 PM, the Administrator confirmed Staff B did not report the allegations of abuse to the management staff until around 3:30 PM on 6/5/25.<br><br>On 6/18/25 at 9:37 AM, Staff B reported on 6/5/25 during breakfast she observed Resident #1 reach for his plate of food and saw Staff A push his hands away. She said Resident #1 reached for the plate of food 3-4 more times and Staff A would swat his hands away. She said each time Staff A would get more and more aggressive with pushing his hands away. She said she was getting ready to intervene when she observed Staff A shove Resident #1's wheelchair away from the table and take him out to the common area. Staff B said she told the Director of Nursing (DON) what had happened sometime between noon and 3 PM. She said she did not witness any injury to Resident #1 and thought allegations of abuse had to be reported in 24 hours if there was no observable injury.<br><br>On 6/18/25 at 2:50 PM, the DON reported she expected staff to report abuse immediately and separate the resident from the alleged abuser.<br><br>The facility policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated 10/19/22 documented all allegations of resident abuse to be reported to the Iowa Department of Inspections and Appeals not later than 2 hours after the allegation was made. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on staff interviews, facility investigation review, time card detail, and policy review the facility failed to separate a staff member from dependent residents accused of alleged abuse that occurred on 6/5/25 at 7:30 AM in a timely manner for 1 of 3 resident reviewed for abuse (Resident #1). The staff member continued to worked her shift and left the facility at 4:40 PM. The facility reported a census of 47 residents.<br><br>Findings include:<br><br>A facility form titled Self Report documented on 6/5/25 at 7:35 AM, Staff A, Certified Nursing Assistant was assisting Resident #1 eating his breakfast. During this time Staff B, Registered Nurse (RN), witnessed Staff A push Resident #1's hands away from his plate as he continued to grab towards it. Staff B stated this occurred multiple times before Staff A quickly wheeled Resident #1 away from the table prior to him completing his meal. The documentation revealed Staff B notified the Administrator regarding the allegations of abuse at approximately 3:30 PM on 6/5/25. The form further documented on 6/5/25 at 3:35 PM, the Director of Nursing (DON) separated Staff A from the residents and at 3:51 PM Staff A was suspended until further notice.<br><br>Review of Time Card Report dated 6/5/25 documented Staff A clocked in at 5:42 AM and clocked out at 4:40 PM.<br><br>On 6/17/25 at 1:15 PM, the Administrator confirmed Staff B did not report the allegations of abuse to the management staff until around 3:30 PM on 6/5/25. The Administrator reported the internal investigation was started and Staff A was suspended at that time. The Administrator verified Staff A had worked with Resident #1 and the other residents throughout the day until she was suspended.<br><br>On 6/18/25 at 9:37 AM, Staff B reported on 6/5/25 during breakfast she observed Resident #1 reach for his plate of food and saw Staff A push his hands away. She said Resident #1 reached for the plate of food 3-4 more times and Staff A would swat his hands away. She said each time Staff A would get more and more aggressive with pushing his hands away. She said she was getting ready to intervene when she observed Staff A shove Resident #1's wheelchair away from the table and take him out to the common area. When asked if she had done anything when Staff A pushed Resident #1 out of the dining room, she said no because the interaction was over. She said Resident #1 was in the common area and Staff A had walked away from him. When asked if Staff A cared for Resident #1 after the incident, she said she could not attest to that. Staff B said she told the Director Nursing what had happened sometime between Noon and 3 PM.<br><br>On 6/18/25 at 2:50 PM, the DON reported she expected staff to report abuse immediately and separate the resident from the alleged abuser.<br><br>(continued on next page) |

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|---|---|---|---|
| | 165455 | A. Building<br>B. Wing | 06/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Accura Healthcare of Carroll | 2241 North West Street<br>Carroll, IA 51401 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated 10/19/22 documented upon receiving a report of an allegation of resident abuse, neglect, exploitation or mistreatment, the facility shall immediately implement measures to prevent further potential abuse of residents from occurring while the facility investigation was in process. If this involves an allegation of abuse by an employee, this will be accomplished by separating the employee accused of abuse from all residents through the following or a combination of the following: (1) suspending the employee; (2) segregating the employee by moving the employee to an area of the facility where there will be no contact with any residents of the facility; and in rare instances (3) separating the employee accused of abuse from the resident alleged to have been abused, but allowing the employee to care for and have contact with other residents, only if there is a second employee who remains with and accompanies the employee accused of abuse at all times to supervise all contacts and interactions with the residents. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinic record review, staff interviews, family interview and policy review, the facility failed to administer medications per physician orders for 1 out of 3 residents reviewed (Resident #3) for significant medication errors. The facility reported a census of 47 residents.<br><br>Findings include:<br><br>Resident #3's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMs) score of 08, indicating moderately impaired cognition. The MDS identified Resident #2 required substantial/maximal assistance with bed mobility and transfers. The MDS included diagnoses of cancer, hypertension (high blood pressure), peripheral vascular disease, chronic obstructive pulmonary disease, malnutrition, depression and chronic pain. The MDS documented Resident #3 had a condition or chronic disease with a life expectancy of less than 6 months and received hospice services while a resident at the facility. The MDS documented Resident #3 had received antidepressant medications during the last 7 days.<br><br>An Incident Report (IR) titled Medication Error dated 4/15/25 documented Staff D, Licensed Practical Nurse (LPN) inadvertently mixed up hospice residents with the same initials and ordered fluoxetine (antidepressant medication) for Resident #3 when the medication was prescribed for Resident #2. The IR documented Resident #3 started the fluoxetine medication on 4/3/25. The IR documented Resident #3's Advance Registered Nurse Practitioner (ARNP) was updated regarding the medication error and a new order received to discontinue the fluoxetine medication for Resident #3. In addition, Hospice was updated and Resident #3's family regarding the medication error.<br><br>Review of April 2025 Medication Administration Record (MAR) documented Resident #3 received fluoxetine 10 mg (milligrams) two times a day from 4/3/25 PM to 4/15/25 AM (24 doses of medication).<br><br>A facility form titled Education Form dated 4/15/25 and signed by Staff D and the Director of Nursing (DON) directed Staff D to read the first and last name for patient identification for the ordering process.<br><br>A Physician Order dated 12/26/24 directed staff to apply fentanyl patch 12 mcg (micrograms) (opioid pain patch) every three days for pain.<br><br>Review of the May 2025 MAR revealed the fentanyl patch was not applied on 5/10/25 and documented a 9 which indicated to see progress notes. The MAR documented the fentanyl patch was applied on 5/13/25 at HS (hour of sleep).<br><br>A Progress Note dated 5/10/25 at 10:04 PM documented Resident #3's fentanyl 12 mcg patch was out of stock and awaiting pharmacy approval from the provider.<br><br>A verbal Physician Order dated 5/10/25 at 10:09 PM directed to hold the fentanyl patch from 5/10 to 5/17/25 due to awaiting pharmacy delivery and provider approval needed. The order was completed by Staff E, LPN. The physician order was signed by the ARNP on 5/13/25.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Progress Note dated 5/12/25 at 10:12 PM documented Resident #3 out of stock fentanyl patches, awaiting pharmacy to deliver and Provider approval. The progress noted documented ARNP and family had been updated and there were no adverse side effects (ASE) from the new patch not being administered.<br><br>A Progress Note dated 5/12/25 at 3:30 PM documented Resident #3 did not have a fentanyl patch in place and the patch was out of stock from the pharmacy with no ASE noted. The progress note documented a fax was sent to ARNP to update Resident #3 did not have a patch in place.<br><br>Review of a form titled Progress Notes dated 5/12/25 revealed Resident #3's ARNP documented on the form on 5/14/25 that the script for the fentanyl patch was sent to the pharmacy on 5/12/25. The ARNP documented the facility can call her in instances like this so the patient did not go without.<br><br>On 6/18/25 at 4:00 PM, Staff D, LPN acknowledged she had made a medication error for Resident #3. She said the Hospice nurse had written an order for Resident #2 for fluoxetine. She said the hospice nurse was standing in the doorway talking about Resident #3. She said as the Hospice nurse was talking, she opened up her computer and put the physician order for fluoxetine in the computer for Resident #3. She said she walked away to do something and when she returned the order was still there and she thought she entered the order again for Resident #2. She said a few days later she had not received the signed order from the attending Physician for the fluoxetine for Resident #3 so she reached out to Hospice. She said the Hospice nurse reported Resident #3 was not on fluoxetine. She said she went back to review the original order for Resident #2 and saw she wrote on the order that Resident #3's daughter had been updated. She said the fluoxetine was in the medication cart for both Resident #2 and #3 and it should have only been in the cart for Resident #2. She said she went to the DON right away and she directed her what to do. She said she contacted the Physician and Resident #3's daughter. She said Resident #3's daughter was not happy at all. She said Resident #3's daughter could not understand how the medication error could happen. Staff D said she apologized for the mistake. She said the DON sat her down and talked to her. She said the DON told her to slow down, double check and had her sign an education form regarding the medication error. When asked about the process for ordering fentanyl patches, she said usually when there was one patch left, the reorder sticker on the box with the prescription and bar code was sent to the pharmacy. She said the pharmacy lets the facility know if a new script is needed. She said it can be frustrating at times getting scripts.<br><br>On 6/19/25 at 11:20 AM, Staff E, LPN verified there had been a time she did not have a fentanyl patch to put on Resident #3. She acknowledged she had completed a physician order to hold the fentanyl patch on 5/10/25 due to unavailability. When asked if she had talked to the Physician on 5/10/25 regarding holding the fentanyl patch, she said no. She said Resident #3's daughter was notified and she was not happy but understood there was not a patch available to put on. She said when there were 1-2 patches left the reorder sticker on the box should have been sent to the pharmacy. She said she was not sure if the patches had been reordered or not.<br><br>On 6/19/25 at 12:00 PM, the DON said she expected the nurses when processing a physician order to read the order, verify it was the right person and then input the order in the computer accurately. She said she expected a 2nd nurse to check, verify and double note the physician order. The DON reported when she became aware of Resident #3's medication error, she reviewed Resident #2 physician orders and saw the fluoxetine order was put in the computer by the Assistant Director of Nursing (ADON) on 4/4/25 and not Staff D. She said Staff D put the order for the fluoxetine in the computer for Resident #3. She said she completed individual education with Staff D on 4/15/25.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/19/25 at 12:15 PM, the DON stated not having the fentanyl patch available for Resident #3 was not acceptable. She said her expectation was for the nurses to reorder the fentanyl patches when there was 1 patch left or when the last patch was applied. She said that had always been the facility process. The DON reported the facility had an emergency kit (Ekit) and she thought there were fentanyl patches in the kit. She said if the fentanyl patch were not available in the Ekit then the nurses should have called the pharmacy as they would bring prescriptions out on the same day even on the weekends. She said if a script was needed to refill the patches then she expected the nurses to call the Physician so the script could be sent to the pharmacy. She said the nurses also had the option to contact Hospice for a script. She said Hospice had a Medical Director available. The DON reported the nurses had resources available to obtain the script. When asked about the verbal order on 5/10/25, the DON said she expected the nurse to call the Physician to obtain a verbal order before a verbal order was written to hold the fentanyl patch. She reported the nurse should not have produced the verbal order without talking to the Physician. The DON verified the Ekit did not have fentanyl 12.5 mcg patches available. The DON reported there were fentanyl 25 mcg patched in the Ekit.<br><br>On 6/19/25 at 1:20 PM, the DON reported she contacted the Pharmacy and the only renewal information they had on file in May 2025 for Resident #3 fentanyl patches was on 5/12/25 from the ARNP.<br><br>On 6/19/25 at 2:14 PM, Resident #3's daughter reported she had concerns regarding her dad's medications. She said he got the wrong medication for two weeks before the facility figured it out. She said the facility brushed the error under the rug. She said the DON reported she would do extensive training but that did not make her feel better. She said there was also an issue with her dad's fentanyl patch and she thought the Physician had dropped the ball. She said she called the Pharmacy and the Pharmacy reported the Physician had not signed off on the patch.<br><br>On 6/24/25 at 3:57 PM, the Administrator reported the facility did not have a policy related to medication errors, she said the facility follows the standards of practice. |