

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2025
NAME OF PROVIDER OR SUPPLIER  Stonehill Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3485 Windsor Avenue Dubuque, IA 52001	
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, clinical record review, and staff interview the facility failed to properly administer insulin from a Kwik pen for 2 out of 2 residents reviewed (Resident #174, Resident #175), resulting in a facility medication error rate of 8%. The facility identified a census of 158 residents. Findings include: 1.) Review of the Medication Administration Record for Resident #174 revealed an order for sliding scale insulin. On 08/06/2025 at 8:05 AM Staff A, Registered Nurse (RN) administered 2 units Lispro insulin via Kwik pen to Resident #174 and did not prime the needle prior to administration. 2.) Review of the Medication Administration Record for Resident #175 revealed a sliding scale order for Lispro Kwik pen insulin. On 08/06/2025 at 9:16 AM Staff A, RN administered 8 units Lispro insulin via a Kwik pen to Resident #175 and she failed to prime the insulin pen prior to medication administration. On 08/04/2025 at 11:59 AM Staff D, Licensed Practical Nurse (LPN) stated to administer insulin from a Kwik pen, clean the tip of the pen, put on the needle, prime the needle with 2 units and then administer the medication. On 08/06/2025 at 3:58 PM Staff A, RN stated should prime the insulin pen with 1 or 2 units and then after it is primed, verify the needle is working. Then could draw up the prescribed dose and then administer. Staff A explained she did not prime the insulin pen for either resident because she was nervous. On 08/07/2025 at 12:29 PM Staff G, RN, Co Director of Nursing (Co DON) stated would expect staff to prime the insulin needle with minimum 2 units prior to drawing up the ordered dose of insulin, and had provided education on this last week. Review of the package insert for Lispro insulin Kwik pen directed to prime before each injection. Priming your pen means removing the air from the needles and the cartridge that may collect during normal use and ensures the pen is working correctly. If you do not prime before each injection you may get too little or too much insulin.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 165471
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</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 - Some</p>	<p>Based on observation, clinical record review, staff interview, and facility policy review the facility failed to properly clean glucometers for 4 out of 4 residents reviewed for blood glucose monitoring (Resident #90, Resident #144, Resident #174, Resident #175). The facility failed to utilize enhanced barrier precautions for 2 out of 3 residents with a gastrostomy tube (Resident #35, Resident #90). The facility identified a census of 158 residents. Findings include: 1.) Review of Resident #90's Care Plan revealed a problem initiated on 7/23/25 for enhanced barrier precautions. It directed staff to wear personal protective equipment while providing direct care including dressing, bathing, toileting, transferring, personal hygiene, assessment/manipulation of device, and linen changes. On 08/06/2025 at 9:32 AM Staff A, Registered Nurse (RN) administered medications via gastrostomy tube to Resident #90. Upon entering the room, Staff A donned a mask and gloves, and failed to put on a gown. The room had a magnet on the door frame with enhanced barrier precautions. The isolation cart in the room had a sign on it which instructed staff to use enhanced barrier precautions with gastrostomy tube. 2.) Review of Resident #35's Care Plan revealed a problem of enhanced barrier precautions dated 5/15/25. It directed staff to wear personal protective equipment while providing direct care including dressing, bathing, toileting, transferring, personal hygiene, assessment/manipulation of device, and linen changes. On 08/06/2025 at 11:19 AM Staff C, RN went in Resident #35's room to administer medications via gastrostomy tube. Staff C failed to put on a mask or don a gown for enhanced barrier precautions. There was a small magnet on the door frame for enhanced barrier precautions. The isolation supply cart inside the room had a sign on top of the cart which stated to use a gown for gastrostomy tube. On 08/06/2025 at 12:14 PM Staff D, Licensed Practical Nurse (LPN) stated she received education on enhanced barrier precautions. Staff D explained it should be used on residents with a catheter or an open wound. Per Staff D, would use them on a gastrostomy tube, and it would entail to gown up and utilize gloves. On 08/06/2025 at 4:00 PM Staff A, RN stated enhanced barrier precautions should be used when providing cares or close contact to a resident with a chronic wound or a catheter. Per Staff A, she should have done it with the gastrostomy tube, and she looked for the magnet on the door which indicated they needed enhance barrier precautions. Staff A explained she walked out of the room and saw the magnet and realized she forgot to wear it for Resident #90. On 08/07/2025 at 12:20 PM Staff G, RN, Director of Nursing (DON) stated facility provided education on enhanced barrier precautions, and did it initially when it came out with hands on training. The DON further explained also provided literature, annually after that, and with the hire of new staff. The DON explained their expectation with enhanced barrier precautions was per the regulation when they were direct care, and the residents who needed enhanced barrier precautions were catheters, chronic wounds, and feeding tubes. Per the DON, would expect them to wear a mask, gown and gloves. The facility provided a policy titled Enhanced Barrier Precautions revised 4/2025 directed staff that enhanced barrier precautions will be initiated for residents with any of the following: Wounds (for example: chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (for example: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO (multidrug-resistant organism). 3.) On 08/06/2025 8:05 AM Staff A, RN checked a blood sugar on Resident #174. She cleaned the glucometer with a hydrogen peroxide wipe, just wiped it, and immediately put it back in the drawer. On 08/06/2025 at 8:20 AM Staff B, RN completed a blood sugar on Resident #144, then cleaned the glucometer with an alcohol wipe, and set it on top of the medication cart. On 08/06/2025 at 9:16 AM Staff A, RN completed a blood sugar on Resident # 175. She wiped the glucometer with a hydrogen peroxide wipe and set it on the medication cart. On 08/06/2025 at 9:32 AM Staff A, RN completed a blood sugar on Resident #90, and wiped the glucometer with a hydrogen peroxide wipe for 4 seconds. On 08/07/2025 12:09 PM Staff E, RN stated glucometers should be cleaned after each using the green sani-wipes, and staff should clean it completely and let it dry. Staff E explained they were used for multiple residents on the unit, hydrogen peroxide wipes were what they used, she was unsure of the wet time, and maybe should be 5 minutes. The wet time was how long it took to completely disinfect and dry it. On 08/07/2025 at 12:11 PM Staff F, LPN stated the policy for cleaning the glucometer was to clean with the green wipes hydrogen peroxide wipes and thought they needed to stay wet for 2 minutes. Alcohol wipes should not be used on the glucometer. The wet time was the time needed to kill off the bacteria, and the glucometers were used on multiple people in the unit. On 8/7/25 at 12:20 PM Staff G, RN DON stated to</p>		