STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165472	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Manor	1409 Fremont Street Iowa Falls, IA 50126

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 40907 Based on clinical record review, family interview, staff interviews and facility document review, the facility failed to notify a resident representative of a change in condition for 1 of 1 resident reviewed (Resident #50). Resident #50 was found to have a large raised area on her lower back on 2/2/24. The facility did not notify Resident #50's resident representative of the area until after the primary care provider (PCP) had seen the area on 2/7/24. The facility reported a census of 60 residents. Findings include: The Minimum Data Set for Resident #50 documented a Brief Interview of Mental Status score of 9 indicating moderately impaired cognition. The Clinical Resident Profile for Resident #50 listed her son as the emergency contact #1. A Timeline for Resident #50 provided by the Director of Nursing (DON) during the survey 5/13/24 to 5/14/24, documented the following: 1/17/24- skin review- no new areas of concern noted by nurse 1/24/24- skin review- no new areas of concern noted by nurse 1/31/24- skin review- no new areas of concern noted by nurse 2/2/24- the PCP notified of being put on rounds for 2/7/24, due to area on the back. No complaints of pain or difficulty. 2/5/24- Tylenol administered for pain, no further complaints and rates pain a zero. 2/7/24-Seen by PCP in house. PCP's note documented other than back pain, has no other complaints. Patient seen at bedside and has what appears to be a left low back mass that looks to be about 10 cm (centimeters) in diameter, protruding and stretching left low back skin. The patient only complained of noticing for couple of days as it's causing discomfort. Staff also does not recall seeing an left low back m ass in the past and she is bathed regularly. Flesh colored, mildly warm, no erythema. PCP wants to send to the ER (emergency room) for evaluation. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165472	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Manor	1409 Fremont Street Iowa Falls, IA 50126

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/7/24- ER notes state psoas (muscle in lower back) muscle mass/abscess extending into abdominal wall and subcutaneous fat. Call clinic in a.m. to make outpatient surgery referral. (Referral indicates no emergency as confirmed by PCP). If symptoms worsen or pain uncontrolled return to ER. 2/8/24 PCP notes he spoke with the son, discharge Hospice Care. discharged from hospice. 2/9/24- surgery scheduled-son (resident representative) took. 2/10/24- notes state likely an obstruction. On 5/13/24 at 1:03 p.m., Resident #50's resident representative stated he had an issue with his mom ending up in the hospital for several days. This representative stated his mother's kidney had erupted, and the urine was going into a pocket causing a lump on her lower back. The resident representative stated that according to the DON it happened over night but when this representative talked to another nurse they said they had been monitoring the area for a couple of weeks. This representative stated the area got to be the size of about 2 soft balls or 1/2 of a basketball. He stated the facility should have let him know when they first seen the area. On 5/15/24 at 11:30 a.m., Staff B, Licensed Practical Nurse (LPN), Stated a Certified Nurse Aide (CNA) was giving this resident a bath on 2/2/24 (Friday) and called Staff B in to look at an area on this resident's back. She stated the skin was intact, there was no redness and it was soft with palpation. The resident had no complaints of pain. The skin was tight around the lump. When asked how large the area was she did not remember. When shown that the provider documented on 2/7/24 (Wednesday) that the area was 10 cm (centimeters). She stated that it was probably that size when she saw it. This LPN stated she didn't feel the area needed to be seen right away or that it was emergent, but she did feel like it needed to be seen by a provider because it was abnormal. When asked if she documented her assessment, she did not remember. She stated she went to the Medical Records person who organizes the doctor's rounds schedules and asked her to put this resident on the schedule for the following week. She stated that she did ask for a different provider to see her on Tuesday but her PCP was scheduled to come on Wednesday, so he went ahead and saw the area on 2/7/24. When this nurse was asked if she notified this resident's representative regarding the area, she stated she did not. She stated she didn't notify him because she wasn't sure what was causing the area, so thought the doctor could take a look and then they would notify him. She stated she should have notified the resident representative the day she first saw the area. She stated she should have told this resident's representative what she observed and that she put this resident on the list to be seen at clinic the following week. Review of the Progress Notes for 2/7/24 revealed no entries regarding the new area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165472	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Manor	1409 Fremont Street Iowa Falls, IA 50126

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 11:51 a.m., Staff E CNA/CMA (Certified Medication Aide), stated that a lot of times this resident refuses her showers. She stated that they were helping Resident #50 get dressed. Staff E stated when she saw the area she was like oh my gosh, this is a big lump on her back. Staff E stated she then called the nurse and reported it. Staff E stated she was not sure what the nurse did after that. Staff E stated that Staff E had kind of rubbed the area lightly to see if it hurt, and Resident #50 said no, it doesn't hurt. Staff E stated the area wasn't red or anything, you could press on it. Staff E stated the area didn't hurt this resident and it wasn't hard, there was just a lump there. Staff A stated the lump was approximately 4 inches or so and dome shaped, it's been a while since Staff E has seen it but the area was raised. The staff stated the resident didn't have any complaints. On 5/15/24 at 4:21 p.m., the Administrator sent an email stating they do not have a facility policy for family notification. On 5/15/24 at 4:30 p.m., the Administrator acknowledged the concern regarding not notifying Resident #50's representative of the area found on Resident #50's back on the day it was found.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165472	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Manor	1409 Fremont Street Iowa Falls, IA 50126

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 49698 Based on observations, record review, staff interviews and manufacturer's insert, the facility failed to provide services that met professional standards regarding medication administration for 2 of 8 residents (Resident #30 twice) observed who did not have their insulin flex pen primed prior to administering insulin (to ensure the proper amount of insulin administered). The facility reported a census of 60 residents. Findings include: During an observation on 5/15/24 at 8:28 AM, Staff A, Registered Nurse (RN) administered Novolog 5 units to Resident #22. Staff A gave the shot in the upper right arm. She did not prime the insulin pen prior to administration. During an observation on 5/15/24 at 8:54 AM, Staff B, Licensed Practical Nurse (LPN) administered Novolog 9 units and Tresiba 54 units to Resident #30. Staff B gave both shots in the upper left arm. She did not prime either insulin pens prior to administration. Review of the facility's Insulin Administration policy, revised September 2014, did not have information specific to insulin pen administration. The policy stated the nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use. During an interview with the Director of Nursing (DON) on 5/15/24 at 3:25 PM, revealed the expectation for nurses is to follow facility policy, indicating following manufacturer instructions. Review of the manufacturer insert for Novolog FlexPen revised 2/2023 stated small amounts of air may collect in the cartridge during normal use. An airshot must be done before each injection to avoid injecting air and to make sure the prescribed dose of the medicine is received. This is done by priming the insulin pen by injecting 2 units of insulin through the attached needle prior to administering the prescribed dose. Review of the manufacturer insert for Tresiba Flextouch Pen revised 7/2022 stated small amounts of air may collect in the cartridge during normal use. An airshot must be done before each injection to avoid injecting air and to make sure the prescribed dose of the medicine is received. This is done by priming the insulin pen by injecting 2 units of insulin through the attached needle prior to administering the prescribed dose.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165472	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Manor	1409 Fremont Street Iowa Falls, IA 50126

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49698 Based on observations, clinical record review, staff interview, and manufacturer's package insert review, the facility failed to keep their medication error rate less than 5 percent. An observation of 39 medications being passed was completed with 3 medication errors noted giving the facility a 7.69% medication error rate. Resident #30 had 2 observations of insulin administration via FlexPen and both observations revealed no priming of the FlexPen. There was no way of knowing if the resident received the appropriate scheduled dose. The facility reported a census of 60 residents. Finding Include: 1. During an observation on 5/15/24 at 8:28 AM, Staff A, Registered Nurse (RN) administered Novolog 5 units to Resident #22. Staff A gave the shot in the upper right arm. She did not prime the insulin pen prior to administration. Review of current physician orders on the May 2024 Medication Administration Record/Treatment Administration Record (MAR/TAR) for Resident #22 revealed the resident to receive the following: a. Novolog Solution 100 UNIT/ML (Insulin Aspart) Inject 5 unit subcutaneous three times daily. Review of the manufacturer insert for Novolog FlexPen revised 2/2023 stated small amounts of air may collect in the cartridge during normal use. An airshot must be done before each injection to avoid injecting air and to make sure the prescribed dose of the medicine is received. This is done by priming the insulin pen by injecting 2 units of insulin through the attached needle prior to administering the prescribed dose. 2. During an observation on 5/15/24 at 8:54 AM, Staff B, Licensed Practical Nurse (LPN) administered Novolog 9 units and Tresiba 54 units to Resident #30. Staff B gave both shots in the upper left arm. She did not prime either insulin pens prior to administration. Review of current physician orders on the May 2024 MAR/TAR for Resident #30 revealed resident was to receive the following: a. Novolog Solution 100 UNIT/ML (Insulin Aspart) Inject 6 units subcutaneous before meals in addition to sliding scale. b. Novolog Solution 100 UNIT/ML (Insulin Aspart) inject as per sliding scale. Based on resident #30's blood glucose reading at the time, resident was to receive an additional 3 units of Novolog for a total of 9 units. c. Tresiba Flextouch Subcutaneous Solution Pen-Injector 100 UNIT/ML Inject 54 units subcutaneous in the morning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165472	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Manor	1409 Fremont Street Iowa Falls, IA 50126

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the manufacturer insert for Tresiba Flextouch Pen revised 7/2022 stated small amounts of air may collect in the cartridge during normal use. An airshot must be done before each injection to avoid injecting air and to make sure the prescribed dose of the medicine is received. This is done by priming the insulin pen by injecting 2 units of insulin through the attached needle prior to administering the prescribed dose. During an interview with the Director of Nursing (DON) on 5/15/24 at 3:25 PM, revealed the expectation for nurses is to follow facility policy, indicating following manufacturer instructions. Review of facility's Insulin Administration policy, revised September 2014, did not have information specific to insulin pen administration. Policy stated the nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165472	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Manor	1409 Fremont Street Iowa Falls, IA 50126

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49698 Based on observations, policy review and staff interview, the facility failed to ensure the medication cart was locked on 2 separate occasions when Staff C, Licensed Practical Nurse (LPN), responsible for the cart, was not in direct sight of the cart. The facility reported a census of 60 residents. Findings include: 1. Observation on 5/13/24 at 12:29 PM revealed a medication cart unlocked and unoccupied on the west hall. Two residents observed self propelling passed the unlocked medication cart. At 12:34 PM (5 minutes later) Staff C, LPN returned to the cart and continued with the medication pass. During an interview on 5/13/24 at 3:48 PM, the facility Administrator revealed it is expected the nurses lock medication carts and computers when stepping away from the cart. 48886 2. On 5/13/24 at 11:33 AM, a medication cart observed unlocked and unattended in the hallway by the main dining room, the court yard dining room. Several residents observed to walk by the medication cart and several residents were seated near the medication cart. The staff member responsible for the cart was not present in the hallway or in the dining hall. Approximately two minutes later a staff member walking through the hallway noticed the medication cart was not locked, locked the cart and continued to walk down the hallway. At approximately 11:37 AM, Staff C, Licensed Practical Nurse (LPN) responsible for the medication cart, came back to the medication cart from another hallway. Staff C not in the dining room or near the medication cart when the medication cart first observed unlocked at 11:33 AM. Review of facility policy, Storage of Medications, with a revision date of November 2020, documents drugs and biologicals used in the facility are stored in locked compartments and compartments containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165472	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Manor	1409 Fremont Street Iowa Falls, IA 50126

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48886 Based on observation, staff interview and policy review, the facility failed to use appropriate infection control practices during urinary catheter care for 1 of 2 residents (Resident #46) reviewed. The facility reported a census of 60 residents. Findings include: The Care Plan for Resident #46, with a revision date of 1/5/24, documented under the focus area the resident has an indwelling catheter and instructed under the intervention and task section to maintain enhanced barrier precautions and to observe and document intake and output. During an observation on 5/14/24 at 4:08 PM, Staff D, CNA, prepared to complete the task of emptying the catheter bag for Resident #46, with the Director of Nursing (DON) present. Staff D her washed hands, donned a gown and donned gloves. Staff D used a gait belt, transferred the resident to his bathroom, and placed the resident on the toilet. Staff D lowered the resident's pants to have access to the leg catheter bag. Staff D placed a plastic container to capture the output inside another larger plastic container as a barrier, with a plastic liner in the larger container. Staff D touched several items with her gloved hands, such as the walker, the gait belt, the containers, the hand rail and the toilet, with the original gloves she placed on her hands prior to moving the resident to the bathroom. Staff D used a sanitizing wipe to wipe down the bag port, then began emptying the bag, wearing the same gloves. The container used to capture the urine output fell over, splashed urine onto the floor and on the resident's legs and inside the larger plastic container. Staff D finished emptying the catheter bag, reattached the bag to the resident's leg and then using the same gloved hands, took paper towels and wiped up the spilled urine off the floor. Using the same gloved hands, Staff D grabbed a wipe and cleaned the resident's legs where urine splashed. The CNA pulled the resident's pants back up, took off the gloves and transferred the resident back to the chair in his room. During an interview on 5/14/24 at 4:25 PM, the DON advised she would have expected Staff D to change gloves after placing Resident #46 on the toilet and before beginning to empty the catheter bag. The DON also advised she would have expected Staff D to change gloves after cleaning up the spillage of urine on the floor and prior to using the wipe to clean the resident. The DON advised Staff D did not follow proper infection control practices. Review of facility policy Catheter Care, Urinary, with a revision date September 2014, documents under the section Infection Control, to maintain clean technique when handling or manipulating the catheter, tubing or drainage bag and avoid splashing.