STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Retirement Community	5501 Gordon Drive East Sioux City, IA 51106

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to ensure that staff followed through with physicians' orders for 1 of 5 residents reviewed. Resident #5 had an order for furosemide (Lasix) related to congestive heart failure and rivastigmine for dementia. Staff failed to ensure that the medications were delivered and administered in a timely manner. The cardiologist directed staff to call if/when Resident #5 had weight gains and staff failed to follow through. The facility reported a census of 70 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #5 had a Brief Interview for Mental Status (BIMS) score of 5 (severe cognitive deficits). Resident #5 was on high risk medications that included a diuretic, opioid and an antiplatelet. She had occasional pain and diagnoses that included heart failure, hypertension, diabetes mellitus, Alzheimer's Disease, The Care Plan for Resident #5, updated on 8/28/24, showed the cardiologist had ordered Lasix and directed staff to obtain daily weights. If there was a gain of 2-3 pounds overnight or 5 pounds in a week, staff were to notify cardiology. The Orders tab showed Resident #5 had the following medication orders: a. furosemide 20 milligrams (mg) 1 tab daily. Order dated 5/22/24. b. rivastigmine patch 4.6 mg/24hr. Order dated 7/2/24. c. rivastigmine patch 9.5mg/24 hour transdermal. Order dated 8/28/24. According to the Medication Administration Record (MAR) for July, the rivastigmine patch 4.6mg. had not been given on the 3rd, 4th, or the 5th because it was unavailable. The August MAR showed that the rivastigmine patch 9.5 mg. had not been given on the 28th, 29th, 30th, 31st and September 1st, 2nd, and 3rd because it was not available. The MARs for Resident #5 showed that the furosemide had not been given on August 31st, [DATE]nd, and 3rd because it was unavailable. The following was included in the Nursing Progress Notes: (continued on next page)

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
	165473	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Retirement Community	5501 Gordon Drive East Sioux City, IA 51106

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	On 8/27/24 at 5:29 PM, the resident had an increase in the Exelon patch to 9.5mg On 8/29/24 at 9:41 AM, the Exelon patch order was faxed to the pharmacy. At 9:42 AM, the medication orders sent to the Veterans Administration (VA). On 8/29/24 at 2:16 PM, the Primary Care Physician (PCP) indicated that scripts had been sent to VA on 8/28/24. On 8/31/24 at 6:23 PM, nurse attempted to call VA regarding furosemide order but the pharmacy was closed. On 9/1/24 at 1:41 PM, nurse called pharmacy for patch but they did not have in stock and will order. On 9/3/24 at 10:19 AM, called to local pharmacy for furosemide and patches, they received the order today. On 9/4/21 at 12:21 PM resident started on increased dose of patch. On 9/24/24 at 10:47 AM, Staff A, Registered Nurse (RN) said that getting medications from VA was sometimes challenging. They assumed that it would take at least 10 days to get the medications delivered so they would try to go to the resident's home pharmacy to get a supply until the VA supply was delivered. She said that she had called the pharmacy several times to try to get the medications for Resident #5. On 9/26/24 at 2:04 PM, Staff E, LPN said that she personally had gone to the pharmacy and got some Lasix for Resident #5 when she was out. According to the Orders tab in the electronic chart, Resident #5 had an order dated 1/12/24, for daily weights. If she had a weight gain of 2-3 pounds overnight, or 5 pounds in week staff were to call cardiology. Resident #5's weights included: On 7/24; 208 pounds (lbs.) on 7/25; 211 lbs. (weighed after breakfast) On 7/28; 208 lbs. on 7/29; 219 lbs. On 7/30; 207 lbs. on 7/31; 210 lbs. On 8/16; 204 lbs. on 8/17; 210 lbs. On 9/7; 195 lbs. on 9/9; 199.8 lbs. The Nursing Notes lacked reference to the weight gain, if there was a re-weigh, or if cardiology had been contacted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Retirement Community	5501 Gordon Drive East Sioux City, IA 51106

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	On 9/25/24 at 1:47 PM, Staff D, Certified Medication Aide (CMA) said that she was aware of weight parameters for Resident #5, and if/when there was a gain, she would weigh again to verify and then tell the nurse. She thought the nurses had followed through. On 9/26/24 at 2:04 PM, Staff E, LPN said that she was aware that the weights for Resident #5 had been out of parameters at times, and it was usually due to factors such as time of day, in or out of wheel chair, things in her chair etc. She said if the weight had been high, she would have asked the next shift re-weigh. She said that she personally called the doctor about weight gains and they said to keep monitoring. She said that she would have documented in the nursing notes or on the MAR. The MAR and Nursing Progress Notes lacked reference to re-weighs or doctor contact on the dates in question. On 9/26/24 at 10:40 AM, the Director of Nursing (DON) said that they've had challenges getting medication for Resident #5 related to family wishes, and processes at the VA, and the pharmacy. The processed medications are delivered to the home, and then they bring them to the facility. They prefer their chosen pharmacy be used in the instances where there is a lag in time to get medications from VA. The DON acknowledged that if a daily weight had been out of parameters, staff should have reweighed and followed through per doctor order. A facility policy titled: Unavailable Medications last reviewed on 12/23/23 showed that the facility would establish a procedure for handling instance when prescribed medications were not immediately available in the facility to ensure resident safety and continuity of care, while minimizing disruptions to treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Retirement Community	5501 Gordon Drive East Sioux City, IA 51106

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to properly monitor and store controlled substances for 2 of 3 residents. Staff failed to destroy controlled medications after the physician's order was discontinued for Resident #36 and #5. They failed to accurately document and verify destruction of controlled medication for Resident #36. The facility reported a census of 70 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #36 had a Brief Interview for Mental Status (BIMS) score of 99 (unable to complete the assessment). The resident was admitted to the facility on [DATE] and had severe cognitive impairment. Resident #36 was totally dependent on staff for transfers, she was receiving hospice services and her diagnoses included; diabetes mellitus, dementia, supraventricular and tachycardia. The Care Plan for Resident #36, updated on [DATE], showed that she was on hospice services from [DATE] - [DATE], and then restarted with hospice on [DATE]. On [DATE], the As Needed (PRN) lorazepam (Ativan) was discontinue due to nonuse. In an observation of medication storage on [DATE] at 10:47 AM, Staff A Registered Nurse (RN) displayed an unused bubble package that contained 14 tabs of Ativan. The sticker showed that the order was dated [DATE]. Staff A said that they would destroy the Ativan if/when it was outdated. She was unsure about how long hospice medications were stored in the cart before being destroyed. According to the Individual Resident Controlled Substance Record (IRCSR) for Resident #36, On [DATE], 14 Ativan was delivered for Resident #36 and none had been used. A separate IRCSR showed the on [DATE], 14 Ativan were delivered and it was used three times, and on [DATE], eleven tabs were destroyed. The Orders tab in the electronic chart showed that Ativan 0.5 milligrams (mg) was renewed on [DATE] and discontinued on [DATE]. On [DATE] at 2:35 PM, the pharmacy said that they had delivered 14 tabs of Ativan on [DATE] and 14 tabs on [DATE]. That order had expired on [DATE]. They received a new order on [DATE], and sent 14 tabs. On [DATE] at 6:25 AM, Staff B, RN said that she was not sure about the policy on destruction of discontinued medications was, but she tried to go through the PRN medication every once in a while to make sure there weren't any out of date. On [DATE] at 3:09 PM, The Director of Nursing and Administrator looked at the orders and the IRCSR sheets and the DON said that they have a process for destroying controlled medications with two nurses once it was discontinued. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Retirement Community	5501 Gordon Drive East Sioux City, IA 51106

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) The MDS dated [DATE] for Resident #5 showed she had a BIMS score of 5 (severe cognitive deficits) and she was admitted to the facility on [DATE]. Resident #5 was on high risk medications that included a diuretic, opioid and an antiplatelet. She had occasional pain and diagnoses that included heart failure, hypertension, diabetes mellitus, Alzheimer's Disease, The Care Plan for Resident #5, updated on [DATE], showed that the cardiologist had ordered Lasix and directed staff to obtain daily weights. If there was a gain of ,d+[DATE] pounds overnight or 5 pounds in a week, staff were to notify cardiology. The resident had complaints of pain to left leg, pelvis and left wrist due to fractures and on [DATE], her PRN tramadol was discontinued. In a review of the IRCSR for Resident #5 revealed that on [DATE], 30 Tramadol 50mg tabs, were delivered to the facility and 21 tabs were destroyed on [DATE]. Staff failed to indicate the disposition of the remaining doses and failed to include a second nurse signature. A second IRCSR showed that 30 tabs of Tramadol were delivered on [DATE] and on [DATE] 30 tabs were destroyed. The form included one nurse signature with no disposition. The Medication Administration Record for Resident #5, in the month of March, showed that the Tramadol 50mg PRN had been discontinued on [DATE]. On [DATE] at 10:40 AM The DON acknowledged that the nurse signing off on the destruction of tramadol did not sign the right place on the form and the disposition of the medication was not included on the form. She said that she would prefer to use a different form. The nurses should have been aware of when a medication was discontinued. A facility policy titled; Discontinued Medications, reviewed on [DATE], showed that staff would follow strict protocols for documenting the removal of controlled substances; including having a witness during the removal and disposal process. Both parties must sign off in the controlled substance log, and quantity destroyed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Retirement Community	5501 Gordon Drive East Sioux City, IA 51106

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on interview, record and policy review the facility failed to ensure accurate and complete resident records for 1 of 16 Residents reviewed, (Resident #5). Resident #5 had a change in medication with an increased dose. Staff documented the resident did not have adverse reaction to the increased dose, even though the medication hadn't been administered. The facility reported a census of 70 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #5 had a Brief Interview for Mental Status (BIMS) score of 5 (severe cognitive deficits). Resident #5 was on high risk medications that included a diuretic, opioid and an antiplatelet. She had occasional pain and diagnoses that included heart failure, hypertension, diabetes mellitus, Alzheimer's Disease, The Care Plan for Resident #5, updated on 8/28/24, showed that the cardiologist had ordered Lasix and directed staff to obtain daily weights. If there was a gain of 2-3 pounds overnight or 5 pounds in a week, staff were to notify cardiology. The Orders tab showed that Resident #5 had the following medication orders: b. rivastigmine patch 4.6 mg/24hr. Order dated 7/2/24 c. rivastigmine patch 9.5mg/24 hour transdermal. Order dated 8/28/24. According to the Medication Administration Record (MAR) for July, the rivastigmine patch 4.6mg. had not been given on the 3rd, 4th, or the 5th because it was unavailable. The August MAR showed that the rivastigmine patch 9.5 mg. had not been given on the 28th, 29th, 30th, 31st and September 1st, 2nd, and 3rd because it was not available. Staff were directed to monitor resident due to rivastigmine increase on 8/27/24. Assess, monitor for adverse reaction and effectiveness of medication document findings in a Progress Note. The Nursing Progress Notes indicated that the resident had no adverse reactions to increase in medication on the following dates: a. 8/29/24 at 8:48 PM b. 9/1/24 at 3:44 AM c. 9/3/24 at 5:57 AM d. 9/4/24 at 2:54 AM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165473	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Retirement Community	5501 Gordon Drive East Sioux City, IA 51106

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 9:01 AM, Staff D, Licensed Practical Nurse (LPN) said that when a resident was put on a new medication or had an increase, there was an automatic alert in the electronic charting for staff to monitor for side effects or change in condition. She said that there was an option to say that medication hadn't been given. She did not remember what she had documented for response on the patch and thought that the alert hadn't come up until after the patch was delivered to the facility. On 9/26/24 at 10:40 AM the Director of Nursing (DON) acknowledged that there was an automatic assessment that popped up in the electronic chart for new medications. The nurses had an option to indicate that it hadn't been given. According to a facility policy titled: Documentation, last reviewed on 8/9/24, all nurse documentation would be completed, accurately, timely and reflect the care provided to the residents. Documentation was essential for ensuring continuity of care, meeting regulatory requirements and supporting legal, financial and clinical responsibilities.