STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165483	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Halcyon House	1015 South Iowa Avenue Washington, IA 52353

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888 Based on clinical record review, facility incident reports, and facility staff interview, the facility failed to administer two doses of insulin for 1 of 3 residents (Resident #1), and remove a transdermal pain patch prior to application of a new patch and notify physician and responsible party of the error for 1 of 3 residents (Resident #2) reviewed for medication administration. The facility reported a census of 51 residents. Findings include: 1. A review of [name redacted] hospital discharge orders, dated 3/6/24, Medication List revealed the following orders, in part: a. Insulin glargine 100 unit/ml (milliliters) (3 ml) injection pen. Dosage: Inject 18 units subcutaneously daily. Last time this was given: 18 units on March 5, 2024 8:50 PM. Diagnosis: Type 2 diabetes mellitus without complication, without long-term current use of insulin. b. CONTOUR NEXT EZ METER Dosage: USE TO CHECK BLOOD SUGAR THREE TIMES A DAY c. SUPPLY CONTOUR NEXT test strips Dosage: Use 1 strip three times a day to test blood sugars. d. SUPPLY lancets Dosage: Use to test blood sugar 4 times daily. Diagnosis: Type 2 diabetes mellitus without complication, without long-term current use of insulin. A review of a N ADV-Clinical Admission document revealed Resident #1 admitted to the facility on [DATE]. The Mental Status section of the document indicated Resident #1 verbal, confused, oriented to person, and a mild cognitive impairment. The assessment did not include information about the need for blood sugar checks. The Baseline Care Plan, Section 3. Health Conditions, dated 3/06/24, indicated Resident #1 diabetic. The D. Medications section did not indicate resident taking insulin. The Care Plan, Date Initiated 3/21/24 and 3/25/24, did not include a Focus area to address a diagnosis of diabetes mellitus, and the use of insulin. (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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the March 2024 Medication Administration Record (MAR), revealed an order for Insulin Glargine Subcutaneous Solution Pen-Injector 100 UNIT/ML (insulin Glargine) Inject 18 units subcutaneously one time a day related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (high blood sugar) Start Date 3/7/24 with D/C (discontinue) Date 3/10/24. A review of the MAR indicated the medication administered in the AM on 3/7/24, 3/8/24, and 3/9/24. A review of the March 2024 MAR revealed an order for Insulin Glargine Subcutaneous Solution Pen-Injector 100 UNIT/ML (insulin Glargine) Inject 18 units subcutaneously one time a day related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA , State Date 3/10/24, D/C Date 4/1/24. A review of the MAR indicated the medication administered HS (bedtime) on 3/10/24 through 3/31/24. A review of the March 2024 MAR revealed an order for HumaLOG KwikPen Subcutaneous Solution Pen-Injector 100 UNIT/ML (Insulin Lispro) Inject 6 unit subcutaneously with meals related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS. Start Date 3/10/24, D/C Date 4/1/24. A review of the MAR indicated Insulin Lispro not administered to the resident three times daily on 3/15/24. The AM and NOON dose coded with a number 9'. The Chart Codes listed on the MAR indicated a 9 is used to communicate Other/See Progress Notes. A review of the March 2024 MAR revealed an order for Blood sugar checks TID (three times) three times a day related TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSPECIFIED Start Date 3/6/24, D/C Date 5/10/24 revealed a number 9 coded for both morning and noon blood sugar checks on 3/15/24. A clinical record review revealed the following notes related to the code number 9: a. On 3/15/24 at 3:57 PM, a X-Orders-Administration Note Note Text: Blood sugars checks TID three times a day related to TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSPECIFIED forgot b. On 3/15/24 at 3:58 PM, a X-Orders-Administration Note Note Text: HumaLOG KwikPen Subcutaneous Solution Pen-Injector 100 UNIT/ML Inject 6 unit subcutaneously with meals related to TYPE @ DIABETES MELLITUS WITHOUT COMPLICATIONS forgot c. On 3/15/24 at 3:59 PM, a X-Orders-Administration Note Note Text: Blood sugars checks TID three times a day related to TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSPECIFIED forgot d. On 3/15/24 at 3:59 PM, a X-Orders-Administration Note Note Text: HumaLOG KwikPen Subcutaneous Solution Pen-Injector 100 UNIT/ML Inject 6 unit subcutaneously with meals related to TYPE @ DIABETES MELLITUS WITHOUT COMPLICATIONS forgot A Nurses Note, dated 3/15/24 at 7:15 PM documented Dexcom (a device for continuous blood sugar monitoring) alarming for high glucose. Monitor reads 268. Fingerstick done shows 300. Monitor calibrated. no s/s (signs/symptoms) hyperglycemia. Scheduled insulin given. Will check again prior to bedtime. An incident report documenting missed insulin doses and blood sugar checks not present in Resident #1 clinical record. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/24 at 1:30 PM, Staff A, Registered Nurse (RN), stated nurses are instructed to alert the Director of Nursing (DON), notify the resident's Primary Care Provider for any additional instructions and notify the resident's responsible party for any omitted medications and then complete an incident report for the occurrence. During an interview 10/24/24 at 2:00 PM, Staff B, Licensed Practical Nurse (LPN), stated if a resident's medication had not been administered, the nurse should notify the doctor and let the family know. On 10/25/24 at 2:33 PM, an email received from the Administrator confirmed Resident #1 morning and noon doses of HumaLOG had been omitted and the facility lacked an incident report on the occurrence. During an interview on 10/28/24 at 10:10 AM, Director of Nursing (DON), stated she would expect nurses to complete a risk management (incident report) for any medication errors and notify the Primary Care Provider right away with medication errors. 2. The Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 for Resident #2, which indicated moderate cognitive impairment. Diagnoses included cancer, arthritis, fractures of left side ribs, and non-Alzheimer's dementia. The MDS indicated Resident #2 required opioid (pain) medication. The Care Plan, revised 8/14/24, revealed Resident #2 utilized pain medication. The Care Plan instructed staff to provide medications as ordered and to monitor/document side effects and effectiveness. A review of the August 2024 MAR revealed an order for Fentanyl 12MCG/HR (micrograms per hour) APPLY ONE PATCH TOPICALLY TO SKIN EVERY 3 DAYS REMOVE OLD PATCH PRIOR TO NEW PATCH, ROTATE SITES (Related Diagnoses: Other chronic pain) Start Date 8/9/24. The MAR revealed Resident #2's Fentanyl patch was changed on 8/30/24 with a new patch applied to the upper back. A review of the September MAR revealed Staff A, Registered Nurse (RN) changed Resident #2's Fentanyl patch on 9/02/24, with a new patch applied to the upper back. The facility provided a document, dated 9/5/24, titled Medication Error. Incident Description Section, Nursing Description: Resident [Resident #2] found 2 fentanyl patches on. One dated 8/30 & one dated 9/2. Patch on 9/2 applied by [name redacted] RN (Registered Nurse). Immediate Action Taken Section, Description: Both patches removed as new one due today. Statement Section: No Statements Found. Agencies/People Notified: [name redacted] Director of Nursing. Notes Section: 9/5/24 Education to staff to check for placement of all patches and remove before applying new patch. DON initialed. A review of Nurses Notes revealed no entry regarding notification of physician and responsible party regarding the medication error. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/24 at 1:30 PM, Staff A, RN stated the process for changing a Fentanyl patch included a check of the resident to ensure the old patch is found and removed before a new patch is applied. Staff A stated she had changed Resident #2's Fentanyl patch on 9/02/24 and recalled being unable to find the old patch on the resident. Staff A revealed that the nurse would complete an incident report when any medication error had been found, which included notification to physician and responsible party. During an interview on 10/28/24 at 10:10 AM, Director of Nursing (DON), stated the expectation of nurses to complete an incident report for any medication error and for timely notification to the provider of incident. DON informed that staff had watched Resident #2 following incident for any side effects and confirmed that Electronic Health Record (EHR) had lacked this documentation.