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	10/14/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, observation, resident and staff interviews, the facility failed to assess and implement interventions and communication with the provider in response to Resident #1's rising blood sugar levels. Resident #1 admitted to the facility on [DATE] at approximately 12:00 PM. Resident #1 list of diagnoses included type 1 diabetes, which required insulin several times a day. At 5:16 PM, facility staff completed a bedside glucose check with a result of 245 mg/dL (milligrams/deciliter). Resident #1 requested insulin be administered. The nursing staff reported to the resident the facility did not have an order for insulin. At 8:02 PM, a second bedside glucose check completed with a result of 324 mg/dL. Resident #1 reported symptoms of hyperglycemia which included cotton mouth, fruity breath, dizziness, brain fog, and unsteadiness. On 10/03/25, at 9:30 AM nursing staff reported to the provider the resident did not feel well and the lab called to report critical values. The provider ordered Resident #1 to go to the emergency room (ER) for an evaluation and treatment. At approximately 9:55 AM, while at the ER, Resident #1 had a blood glucose lab result of 701 mg/dL. The resident admitted to the hospital with a diagnosis of diabetic ketoacidosis (DKA), and acute kidney injury. (DKA is a serious condition that can be life threatening. DKA developed when the body did not have enough insulin to allow the blood sugar into the cells for use as energy. The body responded by breaking down fat in the liver for fuel. The result is the production of ketones, which if produced too fast build up to dangerous levels.) The facility identified a census of 52 residents. On October 9, 2025 at 12:00 PM, the State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of October 2, 2025 at 12:00 p.m. The facility staff removed the Immediate Jeopardy on October 13, 2025 at 3:00 PM by implementing the following actions: 1. Resident #1 discharged to the hospital on [DATE].2. The facility contacted pharmacy to notify of missing insulin on 10/3/25.3. The facility investigated and discovered the pharmacy had not entered orders accurately.4. The facility faxed correct discharge orders.5. Facility educated nurses completing admission to verify orders and the correct order process with pharmacy on 10/3/25.6. Pharmacy will provide facility their plan of corrections to ensure orders are entered accurately by 10/6/25.7. The facility will educate all nurses by end of day 10/3/25 on medication regimen review and confirm all orders. Including the correct process to ensure the orders they confirm match the discharge orders sent from the hospital.8. All nurses working that day were educated on double checking the discharge order from the physician against the orders entered by the pharmacy. All nurses are to call a physician, pharmacy, director of nursing (DON) or assistant director of nursing (ADON) if there are discrepancies.9. The facility will update the admission checklist and review with all nurses by end of day 10/3/25.10. admission checklist will be updated to include: Confirming orders within 4hrs of admission. Notify the provider, pharmacy and the DON or the ADON if any discrepancies in orders or if medication has not come in.11. Any Agency Nurses will be trained on a detailed training plan of assessments, competencies and policies and pharmacy communication.12. The facility will complete admission audits the next business day to ensure all orders and assessments are accurate.13. The facility will educate nurses by 10/9/25 on assessment with blood sugars and to notify the physician if out of parameters. The scope lowered from J to G at the time of the survey after ensuring the facility implemented education and their policy and procedures. Findings Include:Review of Resident #1's Care Plan revealed a Focus area, dated 10/02/25, to address The resident has Diabetes Mellitus. Interventions included, in part:a. Medications and labs as per order. Date Initiated: 10/02/2025.b. Monitor/document/report PRN any s/sx (sign and symptoms) hyperglycemia (high blood sugar): increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abd (abdominal) pain, Kussmaul breathing (type of rapid, deep, and labored breathing pattern that is typically seen in severe metabolic acidosis, such as diabetic ketoacidosis), acetone breath (fruity smelling breath), stupor coma. Date Initiated: 10/02/25.During an interview on 10/07/25 at 2:48 PM, Resident #1 stated she entered the facility on 10/02/25 after she was hospitalized for heart failure. She stated after she arrived the staff did not assess her heart, lungs or check her for swelling. She stated she was asked if she had lunch and had answered no. Resident #1 stated the staff did not bring her lunch or check her blood sugar. Resident #1 added the staff did not weigh her upon admission. She explained while in the hospital she had 10 pounds of fluid removed (heart failure caused an accumulation of fluid) but continued to be hypoxic (low oxygen levels). Resident #1 stated while she waited for an oxygen concentrator to be delivered, she used her portable oxygen. She explained she dozed off and was awakened by the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, resident and staff interviews, the facility failed to provide pain medication after a newly admitted resident reported a pain at 8 out of 10 for 1 of 3 residents (Resident #1) reviewed for pain. The facility reported a census of 52 residents.Findings include:Review of the electronic health record (EHR) revealed a hospital Discharge summary, dated [DATE], which indicated: admission Date: 9/22/2025. discharge: [DATE]. Disposition (discharge arrangements): SNF (Skilled Nursing facility) at HH (abbreviation for facility) .Discharge Diagnoses, in part: Chronic pain, PMR (polymyalgia rheumatica - an inflammatory condition that causes joint and muscle pain in multiple locations), Anxiety, Insomnia, Stage 3b chronic kidney disease, Fibromyalgia (chronic condition that causes widespread body pain), Type 1 diabetes mellitus, AKI (acute kidney injury). The Discharge Summary included a Discharge Medication List, which under the Continue taking these medications section listed the following pain medications orders:a. acetAMINOPHEN 325 mg tablet Take 2 tablets (650 mg total) by mouth every 4 hours as needed for pain or fever.b. cyclobenzaprine 10 mg tablet. Take 1 tablet (10 mg total) by mouth three times daily as needed. Diagnosis: Spasms of the hand or feet.c. oxyCODONE- acetAMINOPHEN 5-325 mg per tablet. Take 1-2 tablets by mouth every 6 hours as needed. Diagnoses: Other chronic pain. d. traZODone 50 mg tablet. Take 1-2 tablets (50-100 mg) by mouth daily at bedtime. Diagnoses: Primary insomnia. Review of the EHR revealed a progress note titled ADV Clinical admission Note, entered on 10/2/25 at 12:20 PM, which included, in part: admission Details: Arrived by private transportation service. Review of the Care Plan, Date Initiated 10/2/25 included a Focus area to address The resident has risk of pain r/t fibromyalgia, PMR, decreased mobility. Interventions included, in part:a. Give pain medication as ordered. Date Initiated. 10/02/25.b. Measure/rate pain on a scale of 1-10 with 10 being the highest. Date Initiated: 10/02/25.c. Monitor/record/report to Nurse any s/sx (sign and symptoms) of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Date Initiated: 10/02/2025d. Notify Dr. (doctor) current pain regime is not effective. Date Initiated: 10/02/25. Review of the resident's EHR revealed Physician Orders, which included, in part:a. Oxycod (oxycodone)/APAP (acetaminophen) tab 5-325 mg (milligrams) take 1 tablet by mouth every 6 hours as needed for pain. Start Date: 10/2/25. b. Acetaminophen (APAP) tab 325 mg take 2 tablets (650 mg) by mouth every 4 hours as needed.(indications for Use: pain). Start Date: 10/2/25. c. Cyclobenzaprine (generic name of a muscle relaxant) 10 mg take 1 tablet by mouth three times daily (TID) as needed for spasms of the hands/feet (indications for Use: muscle spasms). Start Date: 10/02/25.d. Trazodone tab 50 mg take 1 tablet by mouth at bedtime as needed for primary insomnia. Start Date: 10/02/25.e. Trazodone tab 50 mg take 1 tablet by mouth at bedtime as needed for primary insomnia (give w/ (with) scheduled 50 mg=100mg). Start Date: 10/02/25.During an interview on 10/7/25 at 2:48 PM, Resident #1 stated she entered the facility on 10/2/25 for skilled care after a hospitalization for heart failure. She stated she arrived at the facility around noon. Resident #1 explained she suffered from fibromyalgia and routinely took oxycodone for the pain, which she described as being an 8 out of 10. Resident #1 stated she reported her pain to the nurse on admission to the facility. Resident #1 stated she was told that the order for Percocet (a brand name for a pain medication containing oxycodone with APAP) was as needed (commonly called PRN) and not available. The resident reported she was informed the facility only had one dose [Percocet] in the Emergency Kit (or E-Kit, which is a supply of medications provided by the pharmacy for use in the event of a critical need or before the next scheduled delivery of medications). Resident #1 stated she did not receive pain medication on 10/2/25, and was hurting everywhere. Resident #1 stated staff told her that someone could go to her house to get her Percocet, and she told them no she did not want anyone in her house. Resident #1 stated the night nurse did not come back to complete an assessment. Review of the October 2025 Medication Administration Record (MAR) revealed: a. Oxycodone/APAP 5-325 mg 2 tablets every 6 hours as needed. No documentation the medication administered on 10/2/25 or on 10/3/25. b. Acetaminophen 325 mg 2 tablets QID as needed for pain. No documentation the medication administered on 10/2/25 or on 10/3/25.c. Cyclobenzaprine 10 mg TID as needed for spasms of hands/feet. No documentation the medication administered on 10/2/25 or on 10/3/25.d. Trazodone 50mg 1 tablet at bedtime for insomnia