STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165495	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarksville Skilled Nursing & Rehab Center	115 North Hilton St Clarksville, IA 50619

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on record review, staff interviews and Resident Assessment Instrument (RAI) Manual the facility failed to accurately document and submit accurate resident Minimum Data Set (MDS) assessments for 2 of 12 residents reviewed (Resident #15 and Resident #18). The facility reported a census of 35 Residents. Findings include: 1. Resident #15's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), diabetes, and anemia (low blood iron). The MDS lacked documentation of Resident #15's new diagnosis of atrial fibrillation (abnormal heart rate that affects breathing and clotting of the blood) and lacked documentation that she received an anticoagulant during the lookback period. Resident #15's Hospital Discharge Summary dated 2/26/25 documented the principal problem for the hospitalization as atrial fibrillation. In addition, the summary included an order for Eliquis (an anticoagulant medication used to thin the blood to prevent blood clots) to give twice daily. Resident #15's February and March 2025's Medication Administration Record (MAR) reflected they received Eliquis during the seven-day lookback period. During an interview on 4/2/25, the Director of Nursing (DON) reported she reviews the order sheets to determine what medications residents take to code on the MDS. She reported the MDS should have Eliquis coded. She reported the facility didn't have a policy for MDS the facility followed the RAI Manual. The RAI Manual instructed to coded diagnoses in the last 60 days from sources which included hospital discharge summaries. The RAI Manual instructed to code any high-risk medications received during the 7 day lookback period. The RAI listed an anticoagulant as a high-risk medication. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #18's MDS assessment dated [DATE] documented a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of hypertension, hemiplegia (the inability to move one-side of the body or severe weakness on one-side of the body) and Rheumatoid arthritis (a long-term connective tissue disorder that affects movement and comfort). The MDS reflected Resident #18 used bed rails as a restraint (any manual method, physical, or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body). The Care Plan Problem revised 1/29/25 documented Resident #18 couldn't complete bed mobility by herself. The Interventions directed she had bilateral short side rails to the upper half of her bed. She used them to assist with repositioning side to side, and when staff provide care. During an interview on 4/2/25 at 11:20 AM, the DON reported they're not to code side rails on the MDS as a restraint for Resident #18. She added it happened in error. The RAI Manual documented to evaluate whether the resident can easily and voluntarily remove any manual method or physical or mechanical device, material, or equipment attached or adjacent to their body. If the resident cannot easily and voluntarily do this, continue with the assessment to determine whether or not the manual method or physical or mechanical device, material or equipment restrict freedom of movement or restrict the resident's access to their own body. If it does then to code as a restraint.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003 Based on record review, policy review, and staff interviews, the facility failed to follow physician orders. In addition, the facility failed to notify the physician of medication error for 1 of 1 residents reviewed (Resident #36). The facility reported a census of 35 residents. Findings include: Resident #36's Minimum Data Set (MDS) assessment dated [DATE] identified him with severe impaired cognitive skills for daily decision making. The MDS reflected he had a short- and long-term memory problem. The MDS included diagnoses of cancer, dementia, anxiety, and depression. The MDS listed Resident #36 received hospice level of care. Resident #36's Hospice Admission Orders dated 3/5/25, directed to discontinue the following medications: gabapentin (anticonvulsant and nerve pain medication) and Seroquel (antipsychotic medication). Resident #36's March 2025 Medication Administration record included documentation that reflected he received the following medications: a. Start date 3/7/25 - open ended (indicating no end date): Gabapentin tablet 600 milligrams (MG). Give 1 tablet at bedtime. - Staff documented giving him this medication on 3/7/25 and 3/8/25. b. Start date 3/7/25 - open ended: quetiapine (Seroquel) tablet 25 MG. Give 1 tablet twice a day. - Staff documented giving him this medication in the evening of 3/7/25, and both shifts for 3/8/25 and 3/9/25. The clinical record lacked documentation of communication with the physician on error in giving Seroquel and Gabapentin. During an interview on 4/2/25 at 2:15 PM, the Director of Nursing (DON) reported the Assistant Director of Nursing put the orders in and a second nurse verified the orders. The facility sent the provider the orders to review. The DON reported the staff didn't notice until after Resident #36 discharged from the facility the medication discrepancy when they reviewed his chart. She reported no one notified the physician of the error since Resident #36 no longer resided in the building. During an interview on 4/2/25 at 2:40 PM the Physician reported he didn't know of Resident #36's medication errors. He reported he didn't see the patient at the facility and so he didn't know when he signed the orders on 3/11/25 that the facility put the wrong transcription in the system. He reported Resident #36 recently took the medications so it wouldn't have harm concerns since he used it for a long period of time. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated facility policy titled Physician Order Transcription Policy and Procedure Sample for Skilled Nursing Facility directed the facility to accurately document physician orders into the electronic medical records system. The undated facility policy titled Medication Errors directed staff to notify the physician or health care practitioner as soon as possible. Staff are to document actions taken in the medical record.

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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** 48003 Based on record review, policy review and staff interviews, the facility pharmacist failed to provide pharmaceutical services to meet each resident needs by dispensing discontinued medications for 1 of 1 resident reviewed (Resident #36). The facility reported a census of 35 residents. Findings include: Resident #36's Minimum Data Set (MDS) assessment dated [DATE] identified him with severe impaired cognitive skills for daily decision making. The MDS reflected he had a short- and long-term memory problem. The MDS included diagnoses of cancer, dementia, anxiety, and depression. The MDS listed Resident #36 received hospice level of care. Resident #36's Hospice Admission Orders dated 3/5/25, directed to discontinue the following medications: gabapentin (anticonvulsant and nerve pain medication) and Seroquel (antipsychotic medication). The Pharmacy Facility Delivery Log reflected the pharmacy delivered on 3/6/25 Gabapentin and Seroquel for Resident #19. During an interview on 4/2/25 at 3:00 PM, the facility Pharmacist reported the pharmacy has access to the facility's electronic health record (facilities system for electronic charting). The Pharmacist reported he cross referenced the hospice admission orders to the electronic health record and noted the admission orders didn't have an order to continue the Seroquel and gabapentin. The Pharmacist reported he thought they were new orders again since Resident #36 had recently been on them prior to coming to the facility with review of his prior records from the hospital. He reported to not delay Resident #36 receiving his medications so he filled and sent them to the facility. The undated facility policy titled Ordering and Receiving Medications instructed prior to filling any medications, the pharmacist reviews the order and clarified any concerns with the attending physician prior to dispensing.

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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** 48003 Based on record review, policy review and staff interviews, the facility failed to prevent significant medication error for 1 of 1 residents reviewed (Resident #36). The facility reported a census of 35 residents. Findings include: Resident #36's Minimum Data Set (MDS) assessment dated [DATE] identified him with severe impaired cognitive skills for daily decision making. The MDS reflected he had a short- and long-term memory problem. The MDS included diagnoses of cancer, dementia, anxiety, and depression. The MDS listed Resident #36 received hospice level of care. Resident #36's Hospice Admission Orders dated 3/5/25, directed to discontinue the following medications: gabapentin (anticonvulsant and nerve pain medication) and Seroquel (antipsychotic medication). Resident #36's March 2025 Medication Administration record included documentation that reflected he received the following medications: a. Start date 3/7/25 - open ended (indicating no end date): Gabapentin tablet 600 milligrams (MG). Give 1 tablet at bedtime. - Staff documented giving him this medication on 3/7/25 and 3/8/25. b. Start date 3/7/25 - open ended: quetiapine (Seroquel) tablet 25 MG. Give 1 tablet twice a day. - Staff documented giving him this medication in the evening of 3/7/25, and both shifts for 3/8/25 and 3/9/25. During an interview on 4/2/25 at 2:00 PM, the Hospice Nurse reported Resident #36's family called her due to Resident #36 sitting slumped over and very sleepy when they came in the evening on 3/9/25. She reported asking the nurse to review the medication list with her. At that time, they noted the facility gave Resident #36's Seroquel and gabapentin. The Hospice nurse questioned the facility nurse about the discontinued medications but the nurse didn't know a medication error occurred or knew of any concerns of a medication error. Review of the progress notes for Resident #36 lacked documentation of medication errors, an assessment at the time, or any notifications completed after they identified the error. During an interview on 4/2/25 at 2:15 PM, the Director of Nursing (DON) reported the Assistant Director of Nursing put in the orders and a second nurse verified the orders. The facility sent the provider the orders to review. The DON reported the staff didn't notice the medication discrepancy until after Resident #36 discharged from the facility they review his 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	The undated facility policy titled Physician Order Transcription Policy and Procedure Sample for Skilled Nursing Facility directed the facility is to accurately document physician orders into the electronic medical records system. The undated facility policy titled Medication Errors directed to document actions taken in the medical record.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50874 Based on observation, record review and staff interview the facility failed to utilize proper food handling to prevent potential cross contamination of food to prevent food borne illness for 1 meal service observed. The facility reported of census 35 residents. Findings include: The menu for Tuesday, 4/1/25 consisted of the following: a. Chicken dumpling Soup with a buttered croissant b. Pork chop, au gratin potato, creamed peas c. Apple cranberry crunch, peaches and milk. During an observation of the meal service on 4/1/25 at 11:48 AM, Staff A, Dietary Cook, used tongs to place a buttered croissant on a plate. Then used a ladle to place soup into a bowl. They placed the bowl of soup on the plate with the buttered croissant. Staff A used tongs to place four saltine crackers on the plate to the right of the soup bowl. Staff A used her right ungloved hand to place a soup spoon on the plate to the right of the soup bowl on the saltine crackers. Staff A adjusted the soup spoon and saltine crackers with her bare ungloved right hand touching the saltine crackers. At 11:50 AM, Staff A used tongs to place a buttered croissant on a plate. Staff A used a ladle to place soup into a soup bowl and placed the bowl on the plate with the buttered croissant. Staff A, Dietary [NAME] used tongs to remove saltine crackers from a plastic container and placed them to the right of the soup bowl. Staff A, Dietary [NAME] held the tongs in her right ungloved hand and used her ungloved left hand to lift two saltine crackers off the plate. Staff A placed her ungloved middle finger and index finger of her left hand on the edges of the saltine crackers. Staff A grasped the saltine crackers with her left hand and placed them in the plastic tub of ready to eat saltine crackers. During an interview on 4/1/25 at 11:57 AM Staff A acknowledged she touched the saltine crackers with her bare hands and placed them back into the plastic container that held the ready to serve saltine crackers. During an interview on 4/1/25 at 11:59 AM Staff B, Dietary Manager, acknowledged she observed two occasions when Staff A touched the saltine crackers with her bare hands. Staff B reported Staff A should have used tongs to handle the saltine crackers and should have thrown out the saltine cracker instead of placing them back in the plastic container of ready to eat saltine crackers. The undated facility policy titled Food Handling Policy instructed staff to always use a clean, appropriate serving utensil to serve food never use your hand. If hands must be used (i.e. for sandwiches, cookies, etc.), wear clean, disposable gloves.