STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165498	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westhaven Community	112 West Fourth Street Boone, IA 50036

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** 49698 Based on observation, clinical record review, facility policy review, resident and staff interviews, the facility failed to provide services that met professional standards regarding accurately transcribing physician's orders for 1 (Resident #28) of 16 residents reviewed. The facility reported a census of 47 residents. Findings include: Review of Resident #28's Minimum Data Set (MDS) dated [DATE], revealed Resident #28's admission to the facility on [DATE] with a Brief Interview of Mental Status (BIMS) score of 13, indicating Resident #28 as cognitively intact. Resident #28's diagnoses include congestive heart failure (CHF), atrial fibrillation, coronary artery disease, renal insufficiency, and peripheral vascular disease. The MDS also indicated Resident #28 on hospice level of care with oxygen therapy. Resident #28 is independent with mobility with the assistance of a walker. Review of Resident #28's admission orders dated 1/17/25 indicated an order for supplemental oxygen 2-4 liters via nasal cannula for comfort. The Care Plan dated 2/5/25 revealed, Resident #28 and his family have chosen to receive hospice services with interventions to administer medications, oxygen and treatments as ordered for comfort. Review of Hospice Interdisciplinary Meeting (IDT) on 2/10/25 indicated an order, with start date 11/8/24, oxygen via nasal cannula, 2 liters per minute as needed for shortness of breath and breathing comfort. Review of the Medication Administration Record (MAR) for January 2025 indicated a hand written oxygen order, with documentation of Resident #28's use of 2-4 liters supplemented oxygen regularly during the evening and overnight shift and intermittently during the day shift. Review of the MAR for February 2025 indicated a hand written oxygen order, with documentation of Resident #28's use of 2-4 liters supplemented oxygen intermittently during the evening and night shift and rarely during day shift. Review of the MAR's for March and April 2025 failed to indicate an oxygen order and documentation of usage. (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
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders Summary for orders dated 1/17/25-3/31/25, signed by the Physician on 3/14/25, failed to indicate Resident #28's as needed oxygen order. Observation on 3/31/25 at 1:19 PM, revealed a portable oxygen concentrator outside of Resident #28's doorway and an oxygen concentrator in Resident #28's room between the bed and recliner with nasal cannula tubing attached. During an interview on 4/2/25 at 2:30 PM, Resident #28 stated he uses his oxygen as needed and will often wear it at 2 liters for a few hours in the evening, after supper and before bed. During an interview on 4/2/25 at 6:15 PM, Staff D, Co- Director of Nursing (DON) and Staff E, Co-DON stated to their knowledge, Resident #28 doesn't use oxygen and doesn't have an oxygen concentrator in his room. On interview on 4/3/25 at 11:58 AM, Staff D, Co-DON acknowledged the oxygen order for Resident #28 was not included on the MAR's for March and April 2025 or the signed Physician's Order Summary as it should have been. Staff D, Co-DON stated the monthly MAR's are made by transcribing the orders from the Physician's Order Summary to the paper format MAR's and Resident #28's oxygen order had not been discontinued, the facility failed to transcribe the orders accurately. Review of facility provided Checklist for new order medication/treatment procedure indicated the following: 1. New order is written on the MAR/TAR, with date, medication/treatment, route, frequency, time, specific instructions, Also added to the next month ' s MAR/TAR if available. 2. Phone order written if needed. 3. Old order discontinued on MAR/TAR 4. Medications pulled from med cart drawer. 5. New orders for follow up on the calendar. 6. Follow up appointments made. 7. Transportation arrangements made and put in calendar. 8. Family and Pharmacy notified. 9. Entry in nurses notes. 10. Order noted with signature, date and time by nurse.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on clinical record review, resident and staff interviews, and policy review, the facility failed to provide oxygen therapy as prescribed by the physician for 1 of 2 residents reviewed for respiratory care (Resident #3). The facility reported a census of 47. Findings include: Review of Resident #3's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3's Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Diagnoses include atrial fibrillation, chronic obstructive pulmonary disease, coronary artery disease, and heart failure. The MDS further indicated Resident #3 receiving oxygen therapy. During an observation on 4/2/25 at 10:30 AM, the oxygen setting for Resident #3 was at 3 liters. April 2025 Physician Order sheet for Resident #3 revealed the following order: Oxygen at 2 liters to keep oxygen saturation equal to or greater then 89%. Review of the Medication Administration Review (MAR) sheets revealed the following: a. March 2025 MAR showed staff initials indicating oxygen setting was at 2 liters for the month. No further adjustment or updates to the MAR was identified. b. February 2025 MAR revealed an unknown staff member changed the order for oxygen setting to 3 liters from 2 liters. Staff initialed and wrote in an oxygen setting at 3 liters on 2/1/25 and 2/2/25. No date noted on the MAR to indicate when the order on the MAR was changed. Staff initials for the rest of the month indicated the oxygen setting was at 3 liters. c. January 2025 MAR showed staff initials indicating oxygen setting was at 2 liters. No further adjustments or updates to the MAR was identified. d. December 2024 MAR showed staff initials indicating oxygen setting was at 2 liters. No further adjustments or updates to the MAR was identified. Review of the Oxygen Saturation Summary report in the facility's electronic health record revealed the following: a. During the month of March, oxygen setting documented at 3 liters on 3/16/26 and 3/17/25. b. During the month of February, oxygen setting documented at 3 liters on 2/17/25. c. During the month of December, oxygen setting documented at 3 liters on 12/1/24. Review of the electronic medical record as well as the paper medical record, which include all physician orders, lacked documentation to support the change in the oxygen setting from 2 liters to 3 liters as identified from December 2024 to April 2025. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/25 at 12:45 PM, Staff B, Licensed Practical Nurse, could not initially recall Resident #3 current oxygen order and referred to the MAR. When informed of the observation of the oxygen set at 3 liters instead of 2 liters, as ordered, Staff B reported they have typically seen the oxygen set at 3 liters. Staff B could not estimate a time frame on how long the oxygen has been set at 3 liters. Based on their assessment, Resident #3 feels the best at 3 liters. Staff B reported no standing physician orders in place to titrate oxygen settings based on nursing assessments. During an interview 4/2/25 at 2:15 PM, Staff D, Co-Director of Nursing and Staff E, Co-Director of Nursing, both confirmed the facility did not have a protocol or standing orders in place for titrating oxygen settings. Nursing staff would need to contact the physician for any changes. The policy Administration of Oxygen Therapy, revised 10-22, states the oxygen flow rate is set to the prescribed dosage.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observations, staff interview, manufacturer recommendations, and policy review the facility failed to ensure a medication error rate of less than 5%. During observations of medication administration, the facility had 2 errors out of 25 opportunities for error resulting in an error rate of 8.0 % (Residents #31 and #41). The facility identified a census of 47 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had diagnoses of diabetes and renal insufficiency. The MDS documented the resident took insulin 7 of 7 days during the look-back period. The Care Plan initiated 2/12/25 revealed the resident had diabetes. The Care Plan directed staff to administer insulin medication as ordered. The Medication Administration Record (MAR) dated 4/1/25 to 4/30/25 for Resident # 31 listed Novolog 8 units subcutaneous (SQ) administered by Staff B, Licensed Practical Nurse (LPN) on 4/2/25 for the mid-day dose. During observation on 4/2/25 at 10:57 AM, Staff B, Licensed Practical Nurse (LPN), prepared to administer Novolog insulin for Resident #31. After Staff B attached a needle on the end of a Novolog insulin flexpen, Staff B dialed the flexpen to 2 (units) to prime the needle, then turned the dial on the pen to 8. At 11:01 AM, Staff B took the Novolog pen, counted 1, 2, 3, inserted the needle into the resident's left lower abdomen, pushed the button on the end of the insulin pen, and removed the needle after one second. During an interview 4/3/25 at 10:20 AM, Staff D, Co-Director of Nursing (DON) reported she was unsure if the facility had a policy for the insulin flexpens. Staff D reported she expected staff to follow the manufacturer instructions for insulin flexpens. On 4/3/25 at 12:50 PM, Staff D confirmed the facility did not have a policy or procedure for insulin flexpen. On 4/3/25 at 3:15 PM, Staff D reported she checked with the pharmacy about the insulin pens. The insulin pens were all different and the amount of time varied on how long the needle should be left in whenever insulin administered via the flexpen. Staff D stated she planned to tell staff the needle needed to be left in place for 10 seconds whenever they used an insulin flexpen to ensure the residents got the proper dose. According to the Novolog Manufacturer instructions revised 2/2023 revealed the following procedural steps for Novolog insulin injection 100 units/ ml flexpen: a. Turn the dose selector to the number of units needed for injection. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Insert the needle into the skin. c. Press the push button all the way in until the 0 lines up with the pointer. d. Keep the needle in the skin for at least 6 seconds and keep the push button pressed all of the way in until the needle has been pulled out from the skin to ensure the full dose given. 2. The MDS assessment dated [DATE] revealed Resident #41 had diagnoses of diabetes and macular degeneration. The MDS documented the resident took insulin. The Care Plan initiated 2/12/25 revealed the resident had diabetes. Resident #41's MAR dated 4/1/25 to 4/30/25 listed Lispro insulin 100/ml SQ as directed per sliding scale. The MAR listed Lispro insulin 6 units for a blood sugar range of 251-300 was documented on 4/1/25 for the lunch dose. On 4/1/25 at 10:53 AM, Staff A, LPN, checked Resident #41's blood sugar with a blood sugar monitor. Staff A reported the blood sugar reading at 294. At 11:00 AM, Staff A, LPN, prepared an insulin flexpen. Staff A cleansed the end of the insulin pen with alcohol, attached a needle, dialed the pen to 2, and pushed the button on the end of the pen while she held the pen horizontally. Staff A did not remove the needle cap to observe and ensure fluid seen on the end of the needle/pen. Staff A then turned the Lispro insulin dial to 6. Staff A inserted the insulin pen needle into the resident's right lower abdomen, pushed the button on the end of the pen, held the insulin pen in place for 3-4 seconds, then removed the pen. Staff A did not check to ensure the dial showed zero, or hold the flexpen with the needle in the skin for a count of at least 6 seconds after the medication administered. The Lispro Kwikpen manufacturer instructions revised 7/2023 directed staff to prime the pen before each injection to remove air bubbles and check the patency of the needle, and to ensure the resident did not receive too much or too little insulin. The following procedural steps taken to ensure safe and effective usage of the Lispro Kwikpen Injector System: To prime the pen a. Push the capped needle onto the pen and twist the needle on tightly. b. Remove the outer needle cap. c. Turn the dose selector knob to 2 units. d. Hold the pen with the needle pointed up. e. Tap the top of the pen gently a few times to let any air bubbles rise to the top. f. Continue to hold the pen with the needle pointed up. g. Push the dose knob in until the dose counter shows 0. A drop of insulin should appear at the needle tip. Repeat steps until insulin seen at the tip of the needle, up to 6 times. If no insulin drop observed, change the needle and repeat the steps. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Turn the dose knob to select the number of units needed for injection. i. Insert the needle into the skin. j. Push the dose knob all of the way in and continue to hold the dose know in and slowly count to 5 before removing the needle. A diagram on the same page suggested a 5 second hold to the skin. k. Pull the needle out of the skin. l. Check the number in the dose window. If a 0 seen, the full amount of insulin was received.

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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** 34817 Based on clinical record review, observation, staff interview and manufacturer's instructions, the facility failed to administer insulin flexpen to ensure the proper amount of insulin administered for two of two residents observed for insulin administration (Resident #31 and #41). The facility reported a census of 47 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had diagnoses of diabetes and renal insufficiency. The MDS documented the resident took insulin 7 of 7 days during the look-back period. The Care Plan initiated 2/12/25 revealed the resident had diabetes. The Care Plan directed staff to administer insulin medication as ordered. The Medication Administration Record (MAR) dated 4/1/25 to 4/30/25 for Resident # 31 listed Novolog 8 units subcutaneous (SQ) administered on 4/2/25 for the mid-day dose by Staff B, Licensed Practical Nurse (LPN). During observation on 4/2/25 at 10:57 AM, Staff B, Licensed Practical Nurse (LPN), prepared to administer Novolog insulin for Resident #31. Staff B attached a needle on the end of a Novolog insulin flexpen, turned the dial to 2 (units) to prime the needle, then turned the dial to 8. At 11:01 AM, Staff B took the Novolog pen, counted 1, 2, 3, inserted the needle into the resident's left lower abdomen, pushed the button on the end of the insulin pen, and removed the needle after one second. During an interview 4/3/25 at 10:20 AM, Staff D, Co-Director of Nursing (DON) reported she was unsure if the facility had a policy for the insulin flexpens. Staff D reported she expected staff to follow the manufacturer instructions for insulin flexpens. On 4/3/25 at 12:50 PM, Staff D confirmed they facility did not have a policy or procedure for insulin flexpen. On 4/3/25 at 3:15 PM, Staff D reported she checked with the pharmacy about the insulin pens. The insulin pens were all different and the amount of time varied on how long the needle should be left in whenever insulin administered via the flexpen. Staff D stated she planned to tell staff the needle needed to be left in place for 10 seconds whenever they used an insulin flexpen to ensure the residents got the proper dose. According to the Novolog Manufacturer instructions revised 2/2023 revealed the following procedural steps for Novolog insulin injection 100 units/ ml flexpen: a. Turn the dose selector to the number of units needed for injection. b. Insert the needle into the skin. (continued on next page)

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	165498	A. Building B. Wing	04/03/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Press the push button all the way in until the 0 lines up with the pointer. d. Keep the needle in the skin for at least 6 seconds and keep the push button pressed all of the way in until the needle has been pulled out from the skin to ensure the full dose given. 2. The MDS assessment dated [DATE] revealed Resident #41 had diagnoses of diabetes and macular degeneration. The MDS documented the resident took insulin. The Care Plan initiated 2/12/25 revealed the resident had diabetes. Resident #41's MAR dated 4/1/25 to 4/30/25 listed Lispro insulin 100/ml SQ as directed per sliding scale. The MAR listed Lispro insulin 6 units for a blood sugar range of 251-300 was documented on 4/1/25 for the lunch dose. On 4/1/25 at 10:53 AM, Staff A, LPN, checked Resident #41's blood sugar with a blood sugar monitor. Staff A reported the blood sugar reading at 294. At 11:00 AM, Staff A, LPN, prepared an insulin flexpen. Staff A cleansed the end of the insulin pen with alcohol, attached a needle, turned the dial on the pen to 2, and pushed the button on the end of the pen as she held the pen horizontally. Staff A did not remove the needle cap to observe and ensure fluid seen on the end of the needle/pen. Staff A then turned the Lispro insulin dial to 6. Staff A inserted the insulin flexpen needle into the resident's right lower abdomen, pushed the button on the end of the pen, held the insulin pen in place for 3-4 seconds, then removed the needle from the administration site. Staff A did not check to ensure the dial showed zero, or hold the flexpen with the needle in the skin for a count of at least 6 seconds after the medication administered. The Lispro Kwikpen manufacturer instructions revised 7/2023 directed staff to prime the pen before each injection to remove air bubbles and check the patency of the needle, and to ensure the resident did not receive too much or too little insulin. The following procedural steps taken to ensure safe and effective usage of the Lispro Kwikpen Injector System: To prime the pen a. Push the capped needle onto the pen and twist the needle on tightly. b. Remove the outer needle cap. c. Turn the dose selector knob to 2 units. d. Hold the pen with the needle pointed up. e. Tap the top of the pen gently a few times to let any air bubbles rise to the top. f. Continue to hold the pen with the needle pointed up. g. Push the dose knob in until the dose counter shows 0. A drop of insulin should appear at the needle tip. Repeat steps until insulin seen at the tip of the needle, up to 6 times. If no insulin drop observed, change the needle and repeat the steps. (continued on next page)

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	165498	A. Building B. Wing	04/03/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Turn the dose knob to select the number of units needed for injection. i. Insert the needle into the skin. j. Push the dose knob all of the way in and continue to hold the dose know in and slowly count to 5 before removing the needle. A diagram on the same page suggested a 5 second hold to the skin. k. Pull the needle out of the skin. l. Check the number in the dose window. If a 0 seen, the full amount of insulin was received.

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	165498	A. Building B. Wing	04/03/2025

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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 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. 50500 Based on observation, staff interviews, and policy review, the facility failed to safely and securely store resident and staff medications. The facility reported a census of 47. Findings include: During an observation on 3/31/25 at 10:00 AM, several over-the-counter medications were found in an unlocked cupboard in a prep area of the kitchen. The kitchen did not have a secured entrance. Medications included Pepto-Bismol, Ibuprofen, Tylenol, Tylenol Arthritis, Tums, and allergy relief. During an observation on 3/31/25 at 11:25 AM, the 100-hall treatment cart was unlocked. The cart had Biofreeze, Nystop powder, Diclofenac cream, and dressing supplies all with resident names. During an observation on 3/31/25 at 11:25 AM, Albuterol and Budesemide inhalers were seen on Resident #9's bedside table in their room. The inhalers were not labeled with any resident names. During an interview on 3/31/25 at 10:20 AM the Certified Dietary Manager, CDM, acknowledged the unsecured medications. The CDM reported these are for staff use. During an interview on 4/3/25 at 10:30 AM, Staff E, Co-Director of Nursing, reported medications are stored in on the medication cart or in the medication room. Resident inhalers are stored on the medication cart. Staff E believed Resident #9's family may have brought in the unlabeled inhalers. During an interview on 4/3/25 at 1:40 PM, Staff D and Staff E, both Co-Directors of Nursing, indicated the over-the-counter medications in the kitchen should have been, at the very least, locked-up. The undated policy Medication Labeling and Storage stated resident medications are properly labeled (name, room number, medication name, directions for use) and locked in a cart or cabinet. Medications for each resident are kept and stored in their originally received containers. Containers having no labels are to be destroyed in accordance with state and federal laws.

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	165498	A. Building B. Wing	04/03/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observations, staff interviews, and policy review, the facility failed to disinfect equipment after resident use and failed to ensure staff changed gloves and sanitized hands in accordance with proper infection control techniques when contaminated to protect against cross contamination and potential infection for 4 of 8 residents observed during medication administration and for 2 of 3 residents observed for cares. The facility reported a census of 47 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 had diagnosis of chronic obstructive pulmonary disease (COPD) and heart failure. The Care Plan initiated 1/16/25 revealed the resident had lung cancer. The Care Plan directed staff to use a spacer whenever inhalers administered. During observation on 4/2/25 at 11:13 AM, Staff B, Licensed Practical Nurse (LPN), attached a Combivent inhaler to a spacer with a mask attached to it. Staff B placed the mask on Resident #3's face covering the resident's nose and mouth. Staff B then administered the inhaler to the resident and had the resident inhale the medication. After Staff B administered the medication and had the resident rinse her mouth with water, Staff B placed the spacer and mask back in the bottom drawer of the medication cart without cleaning or disinfecting the mask. During an interview 4/3/25 at 10:20 AM, Staff D, Co-Director of Nursing (DON) reported she expected staff to rinse the mask used with the inhaler for the resident with water and air dried. An Administration of Metered Dose Inhalers revised 4/2012 revealed to replace the inhaler in a proper storage area. The policy lacked information related to care of the inhaler administration device after the medication administered. A Standard Precautions policy reviewed 6/10/21 revealed resident care equipment disinfected before resident use. 2. During observation on 4/1/25 at 2:40 PM, Staff G, certified nursing assistant (CNA), removed Resident #3's pants and brief. Staff H, CNA, handed disposable wipes to Staff G. Staff G provided pericare to Resident #3. Staff G continued to wear the same gloves after pericare provided and transferred the resident from the bed to the commode. Staff G donned the resident's shoes, then placed a sling under the resident. Staff touched the mechanical lift and the commode, then transferred the resident from the bed to the commode wearing the same gloves. Staff G then removed her gloves and sanitized her hands. Staff bagged up the trash, and placed the soiled clothes and sling into a plastic bag. Staff moved the mechanical lift into the hall/common area but did not disinfect the mechanical lift after use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Westhaven Community	112 West Fourth Street Boone, IA 50036

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 - Some	At 3:05 PM, Staff G and Staff H returned to the resident's room. Staff G and Staff H moved the resident from the commode to the bed. Staff H provided disposable wipes to Staff G. Staff G continued to wear the same gloves and provided pericare to Resident #3. Staff G did not change gloves or sanitize her hands after she transferred the resident and after she performed pericare for the resident. Staff G touched the overhead trapeze and provided the trapeze to the resident to use as she turned side to side in bed. Staff G donned a clean brief on the resident, touched the bed sheets and blankets, the call light, and the bed control, then removed her gloves. At 3:25 PM, staff took the mechanical lift from the resident's room and placed it in a common area. Staff did not disinfect the mechanical lift after use. At 3:30 PM, Staff G, CNA, reported she asked nursing about wipes but did not get a response on where she could obtain the wipes. Staff G placed the used commode back into the bathroom that was shared with another resident. Staff G used a personal care wipe to wipe off the commode. Staff G stated Resident #3 was the only resident who utilized the commode. A Hand Washing Techniques dates 1/28/20 revealed hand washing reduced the spread of potential pathogens on the hands and prevent nosocomial infections. Hands washed before and after resident contact, after contact with body fluids, inanimate objects that are likely to be contaminated and after gloves removed. Hands sanitized with an alcohol-based handrub when persistent antimicrobial activity on the hands is desired or before an invasive procedure performed. Hands much be washed thoroughly with soap and water when visibly soiled. Gloves should be removed and hands washed whenever staff performed hand-contaminating activities. Gloves changed whenever moved from one procedure to another. 3. The MDS assessment dated [DATE] revealed Resident #30 had diagnosis of dementia. The MDS recorded the resident had incontinence and dependent on staff for toileting hygiene and lower body dressing. The Care Plan initiated 1/22/25 revealed the resident had memory loss and urinary infections, and required assistance with cares. The Care Plan directed staff to toilet the resident as needed and provide assistance of one staff for hygiene and dressing. During observation on 4/2/25 at 1:35 PM, Staff I, CNA, provided incontinence care for Resident #30 while he stood by a grab bar in the bathroom. Staff I took disposable wipes and cleansed the resident's buttocks area, then pulled the resident's pants up. Staff I continued to wear the same gloves, bagged up the trash, and walked down the hall to the utility room. Staff I entered a code on the utility room door, turned the knob on the door with her gloved hand, placed the bag of trash in a barrel, placed the lid over the barrel, and then removed one glove. Staff I walked back to the resident's room, closed the bathroom door and activated the alarm by the bathroom door. Staff I walked to the nurse's station across from the resident's room and removed the glove on her other hand. During an interview 4/3/25 at 10:30 AM, Staff E, Co-DON, reported she expected gloves changed whenever going from a dirty task or area to a clean task or area. Staff E reported she expected staff performed hand hygiene and removed gloves and wash hands when visibly contaminated. She also expected staff washed hands after tasks completed such as after resident cares. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Standard Precautions policy reviewed 6/10/21 revealed hands washed after touching body fluids and contaminated items regardless of whether gloves are worn, after gloves removed. Hands washed or hand sanitized between tasks and procedures on the same resident to prevent cross contamination. Gloves changed after contact with material that may contain high concentrations of microorganisms. Resident care equipment disinfected before resident use. 4. During observation on 4/2/25 at 11:01 AM, Staff B, LPN, administered insulin to Resident #31. Staff B recapped the end of the flexpen, then removed the needle from the pen, and disposed of the needle device into a sharps container by the medication cart. During an interview on 4/2/25 at 1:40 PM, Staff F, Registered Nurse (RN), reported the needles used and attached to the insulin flexpens do not automatically retract whenever an injection given. During an interview 4/3/25 at 10:20 AM, Staff D, Co-DON reported staff should never recap needles. On 4/3/25 at 11:15 AM, Staff D and Staff E requested the surveyor to look at the needle devices used on their insulin pens. Staff D explained they used a drop safe needle for insulin injections. The needles were obtained from their supplier. At the time, Staff D had Staff B demonstrate application of the needle device onto an insulin pen and then Staff B administered the insulin into a cotton ball. A bent needle was observed inside the plastic chamber. On 4/3/25 at 12:50 PM, Staff D confirmed they facility did not have a policy or procedure for insulin flexpen use. The facility's Injections Subcutaneous policy revealed using the safety syringe device cover the exposed needle. Dispose of the syringe and needle in the designated container. DO NOT RECAP NEEDLE! According to the Novolog Manufacturer instructions revised 2/2023 revealed do not recap the needle. Recapping can lead to a needle stick injury. Carefully slip the needle into the outer needle cap. Safely remove the needle and throw it away into a sharps disposal container after use. 5. The MDS assessment dated [DATE] revealed Resident #36 had a cardiorespiratory condition. During observation on 4/2/25 at 10:00 AM, Staff B, LPN, pushed a cart with a stethoscope, pulse oximeter machine, and blood pressure cuff on the top shelf, and three boxes of gloves on the middle shelf into Resident #36's room. Staff B placed an albuterol solution into a nebulizer chamber, attached the mask, and connected the tubing to the nebulizer machine. Staff B placed the nebulizer machine on top of the cart that she brought into the resident's room, then administered the nebulizer treatment to the resident. At 10:22 AM, Staff B removed the nebulizer mask from the resident's face then provided a washcloth for the resident to wash her face. Staff B moved the nebulizer machine to a bedside table, then placed the soiled washcloth on top of the cart. At 10:30 AM, Staff B pushed the cart with the soiled washcloth, blood pressure cuff, stethoscope, and pulse oximeter back to the nurse's station. Staff B took the soiled washcloth to the soiled utility room, removed her glove, and sanitized her hands. Staff B then spoke with another staff member by the desk. At 10:35 AM, Staff B wheeled the cart with the medical equipment down the hall and into another resident's room and took the resident's vital signs. Staff B did not clean or disinfect the cart before or after use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 4/3/25 at 10:20 AM, Staff D, Co-DON reported she expected staff used germicidal wipes to disinfect equipment such as the mechanical lifts and carts. The equipment or surface needed to remain wet for 2 minutes to ensure the equipment or the surface had been properly disinfected. A General Infection Prevention and Control Nursing Policy reviewed 4/25/23 revealed all items for multi-resident use will be disinfected using germicidal wipes after use. 6. On 4/1/25 at 10:53 AM, Staff A, LPN, removed the blood sugar machine from a drawer in Resident #41's room, donned a pair of gloves, and cleaned the machine with an alcohol swab. Staff A took another alcohol swab and cleansed the resident's finger, then took a lancet and poked the resident's finger. Staff A placed a drop of blood on the strip in the blood sugar machine. After Staff A read the blood sugar result, she removed her gloves and disposed of items in the trash. Staff A did not change her gloves or sanitize her hands in-between cleaning the blood sugar machine and performing the blood sugar check. On 4/1/25 at 11:00 AM, Staff A prepared and administered insulin to Resident #41. Staff A recapped the needle, then disposed of the needle in the sharps container on the medication cart. During an interview 4/3/25 at 10:30 AM, Staff E, Co-DON, reported she expected gloves changed whenever going from a dirty task or area to a clean task or area. Staff E reported she expected staff performed hand hygiene and removed gloves and wash hands when visibly contaminated. She also expected staff washed hands after tasks completed such as after resident cares. A Standard Precautions policy reviewed 6/10/21 revealed hands washed after touching body fluids and contaminated items regardless of whether gloves are worn, after gloves removed. Hands washed or hand sanitized between tasks and procedures on the same resident to prevent cross contamination. Gloves changed after contact with material that may contain high concentrations of microorganisms. 7. During observation on 4/2/25 at 3:30 PM, Staff C, RN, donned gloves and administered Debrox Earwax ear drops into Resident #52's ears. Staff C then took latanopost eye drops and instilled a drop into each eye. Staff C did not change gloves or sanitize hands after she administered the ear drops and before she administered the eye drops. During an interview 4/3/25 at 10:30 AM, Staff E, Co-DON, reported she expected staff changed gloves in-between giving medications, including going from one route of medication to another. For example, staff should change gloves after an ear medication administered and before an eye medication administered. A Standard Precautions policy reviewed 6/10/21 revealed hands washed or hand sanitized between tasks and procedures on the same resident to prevent cross contamination. Gloves changed after contact with material that may contain high concentrations of microorganisms.