Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165500	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rotary Senior Living	500 South Blaine Avenue Eagle Grove, IA 50533

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on observation, clinical record review, policy review and staff interview the facility staff failed to do the scheduled controlled medication shift counts as directed by facility policy. In addition, the facility failed to destroy a discontinued narcotic medication for 1 out of 3 residents reviewed (Resident #1). The facility census was 31 residents. Finding include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] a Brief Interview for Mental Status (BIMS) score of 6, indicating severely impaired cognition. The MDS included diagnoses of arthritis, osteoporosis, recent hip fracture, Alzheimer's dementia, and anxiety. Resident #1 received an opioid (pain medication) in the 7-day lookback period. The After-Visit Summary dated 11/6/23 included an order for Oxycodone (pain medication) 5 milligrams (mg) immediate release tablets. The order directed to give 0.5 tablets, (2.5 mg total) by mouth every 6 hours as needed for pain. Resident #1's November 2023's Medication Administration Record (MAR) listed the order for Oxycodone 5 mg, give 0.5 tablet by mouth every 6 hours as needed. - Documentation indicated Resident #1 received a dose for a pain level of 10, indicating severe pain on 11/6/23 at 5:59 p.m. The Nursing Note dated 11/7/23 at 10:19 a.m., indicated Resident #1 saw the provider who discontinued her Oxycodone order. The Physician telephone orders dated 11/7/23, included an order to discontinue Oxycodone. The Progress Notes dated 11/8/24 at 8:21 a.m., documented new orders to start Oxycodone 2.5 mg by mouth every 4 hours as needed for pain. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2024
NAME OF PROVIDER OR SUPPLIER Rotary Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 500 South Blaine Avenue Eagle Grove, IA 50533	

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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	The Facility's Self-Report dated 11/8/23, included the following Description of Alleged Occurrence: The provider discontinued Resident #1's Oxycodone order on 11/7/23 at 10:15 a.m. The facility discovered the Oxycodone medication card with the remaining 37, (half tabs), and narcotic count sheet missing on 11/8/23 at 8:45 a.m. On 4/10/24 at 11:30 a.m., Staff A, Registered Nurse (RN), stated that on 11/7/23, the primary care physician (PCP) came to the facility to do rounds, as Resident #1 appeared more lethargic and didn't track. The PCP discontinued the Oxycodone; however, Staff A didn't destroy the Oxycodone as directed by the facility policy/procedure when a narcotic is discontinued. Staff A left the medication card and the narcotic sheet in the medication narcotic box and binder. Staff A and Staff B, licensed practical nurse (LPN), did the narcotic count at 6:00 p.m., on 11/7/23. Staff A and Staff B failed to do the narcotic count per the facility's policy/procedure. On 11/8/23 at 6:00 a.m., Staff A and Staff B proceeded to do narcotic count again. They continued to not follow the facility policy and procedure for counting narcotics. Staff A stated that when the staff gave Resident #1 a shower, she complained about hip pain. Staff A called the physician and received orders to re-start the Oxycodone for Resident #1. Staff A, knowing no one destroyed the Oxycodone after the PCP discontinued the order on 11/7/23, she went to the narcotic box. When she looked in the narcotic box, she discovered Resident #1's Oxycodone card and narcotic sheet missing. Staff A went to the facility's Director of Nursing (DON) and Administrator and explained what happened, then they started an investigation. On 4/10/24 at 2:30 p.m., Staff B, confirmed they didn't complete the narcotic count as directed by the policy and procedures with Staff A on 11/7/23 at 6:00 p.m., and on 11/8/23 at 6:00 a.m. Staff B couldn't confirm if the narcotic box contained Resident #1's Oxycodone. On 4/11/24 at 2:10 p.m., the Administrator verified they expected the nursing staff to count the medications per facility policy/procedure. If the provider discontinued a narcotic medication, the facility must waste the medication right away with another nurse. On 4/11/24 at 11:00 a.m., narcotic controlled count completed by Staff C, LPN, and Staff D, RN. Both nurses verified the count as accurate. They followed the facility policy and procedure for counting narcotics. The Narcotic Count Policy dated 5/2/23, Purpose: The purpose of this policy is to ensure that all narcotic medications are safely and securely stored, administered, and accounted for in accordance with state and federal laws and regulations. A narcotic count will be completed by two employees within 60 minutes prior to the end of each shift. Any unresolved discrepancies/errors will be reported to the director of nursing for follow-up. Narcotics wasted will be witnessed and cosigned by two employees, including the RN, LPN or CMA. Narcotic wasted will be witnessed and cosigned by two employees.