

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165502	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Hillcrest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 915 West First Street Sumner, IA 50674	

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)
<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072</p> <p>Based on observation, record review, and staff interviews the facility failed to follow a physician order resulting in an emergency room visit for 1 out of 3 residents reviewed for medication administration (Resident #2). The facility reported a census of 47 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) dated [DATE] revealed Resident #2 had a BIMS score of 10 which indicates moderate impairment of cognitive status. The MDS indicated she had hallucinations and verbal aggression directed toward others. The MDS revealed Resident #2 has diagnoses of Anxiety and Depression.</p> <p>On 4/24/24 at 8:49 AM observed Resident #2 sitting in her wheelchair in her room. She responded to the nurse knocking on her door and refused her medications. She wanted them left in the room but the nurse explained she needed to watch her take them. The Director of Nursing came and talked to resident and convinced her to take the medications.</p> <p>Resident #2 Care Plan initiated on 9/20/22 indicated behavior problem (yelling/screaming, swearing, sad/tearful/crying, repetitive movement, repetitive questions, rejection of care, abusive language, agitation, anxious/restless, accusing others, physical aggression, hitting staff) due to not trusting staff or the way staff approach her. The interventions with a revision date of 9/8/23 directed staff to administer medications as ordered. Monitor/document for side effects and effectiveness.</p> <p>Review of the Nurse Progress Note dated 2/15/24 at 2:47 PM revealed anxious behaviors and the nurse contacted Resident #2 nurse practitioner. Noted it appears resident is having a panic/anxiety attack. A one time order for Lorazepam (medication to reduce anxiety) 1 milligram(mg) was given per the nurse practitioner.</p> <p>The Nurse Progress Note dated 2/15/24 at 3:15 PM revealed the one time dose of Lorazepam was administered.</p> <p>The Nurse Progress Note on 2/15/24 at 5:48 PM revealed nurse was called to room due to Resident #2 lowered to the floor. No injuries noted at this time. Vital signs: Blood pressure (BP) 70/43, Pulse (P) 120, Respirations (R) 20, Temperature (T) 97.5 degrees, Oxygen saturation (O2 sat) was 89 percent on room air. Resident assisted to her wheelchair and recheck of her vitals BP 106/62, P 103, R 18 and O2 sat 96% on room air.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Nurse Progress Note on 2/15/24 11:52 PM revealed the nurse called to Resident #2's room due to she was again lowered to the floor. During the assessment she was lethargic, unable to help stand. BP 70/43, P 120, R 20, T 97.5, O2 sat 89% on room air, recheck of the vitals after settled in her wheelchair revealed BP 106/62, P 103, R 18, O2 sat 96% on room air. No injuries noted.</p> <p>The Nurse Progress Note on 2/16/24 at 12:57 AM revealed a condition report was called to the physician on-call and an order was obtained to send Resident #2 to the emergency department.</p> <p>The Emergency Department Provider Note from 2/16/24 at 2:16 AM revealed at 5:48 PM on 2/15/24 her oxygen saturation was 89% on room air and 96% on room air soon thereafter. At 12:10 AM on 2/16/24, her oxygen saturation was 94% on room air. But at around 1:30 AM nursing home staff contacted the physician on call in the emergency department to inform us of hypoxemia again noted in the patient with an O2 sat of 79%. She was placed on low-flow supplemental oxygen, and emergency services notified. Responding medics placed her on 10 Liters non-rebreather mask at the time of transport.</p> <p>According to the review of her nursing home notes, the patient had been increasingly confused and somewhat combative/resistive with staff over at least the preceding day. She is normally well-oriented per staff. However she is now rather confused. According to her review of the notes, she did not know the year and did not know her son's name. This is not typical for her. In addition the patient was accidentally given Seroquel (antipsychotic medication) 12.5 mg earlier in the evening. This is not a medication that is prescribed to the patient.</p> <p>Resident #2 presented to the emergency department in acute hypoxemic respiratory failure with a significant oxygen requirement, requiring 10 Liters (L) by non-rebreather mask, She was acutely confused, possibility due to acute hypoxia. In the hours leading up to her decline and subsequent ER transfer, the patient had been given a benzodiazepine (Lorazepam) ordered by her primary care physician in addition to later being given a dose of Seroquel accidentally by nursing home staff. Chest imaging with plain radiographs and CT demonstrated no evidence of heart failure or pulmonary infectious process which would otherwise explain her hypoxemia. COVID-19, influenza and RSV testing was negative. Evaluation of concern for pulmonary embolism was within normal limits. Final diagnosis acute hypoxemic respiratory failure requires continuous at home supplemental oxygen. Medication administered in error, accidental or unintentional, bilateral lower leg cellulitis.</p> <p>A follow up visit Progress Note dated 2/19/24 from Resident #2 primary care nurse practitioner revealed follow up after ER visit last. Resident is not wearing oxygen, says she does not want to. Resident #2 O2 sat 95% on room air. Resident cognitively intact.</p> <p>Review of the Electronic Medication Administration Record (EMAR) for February 2024 revealed no order for Seroquel for Resident #2.</p> <p>On 4/24/24 8:54 AM the Director of Nursing(DON) stated Staff B, Certified Medication Aide (CMA) was terminated for giving someone a medication there was no prescription for. He admitted to doing it. No other problems with him prior to this incident. It was Resident #2 and she was having other health issues at the same time. She went to the emergency room for shortness of breath and she ended up having cellulitis of the leg. They do track medication errors in the risk management.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/24 at 8:35 AM Staff A, Registered Nurse (RN) reported on 2/15/24 Staff B, Certified Medication Aide (CMA) made a statement to her about doing something but probably not something he should tell her. He told her he gave another residents Seroquel (antipsychotic medication) to Resident #2. She stated it was about 5:30 PM when he told her and her shift ended at 6:00 PM so she passed it onto the oncoming nurse.</p> <p>On 4/25/24 at 9:46 AM with Staff B, CMA stated Resident #2 had behaviors on 2/15/24 and I went to the nurse in charge and asked if I could give her a Seroquel and she said she sure could use it so I interpreted it as to go ahead and give it. I gave her the Seroquel from another residents medications. He stated before administering a medication you should follow the 7 rights of medication administration and ensure you have the right person, right dose, right route, right medication, right time, right reason and right documentation, needs to be followed. He acknowledged you should never give a medication without a physician order and Resident #2 did not have a physician order on the EMAR for Seroquel.</p> <p>On 4/25/24 at 10:34 AM the Assistant Director of Nursing (ADON) stated on 2/15/24 Resident #2 appeared anxious and agitated, more than usual. A nurse got a one time order and administered Lorazepam (antianxiety medication) around 3 PM. Staff B, CMA came to my office and stated Resident #2 was out of control and needed to be sent out. I informed him she just had a dose of Lorazepam. Around 5:00 PM I was leaving for the day and stopped Staff B to ask how Resident #2 was doing and he stated not great. I visually saw her sleeping and Staff B did not say anything about giving her any medications. Sometime later in the evening the nurse made him call and he told me he did something he should not have and gave Resident #2 someone else medication.</p> <p>The facility provided a policy titled Oral Medication Administration with no date, the purpose is to provide a medication regimen safely and effectively. The procedure directed staff to:</p> <ol style="list-style-type: none"> 1.) Open the MAR in computer, locate resident, review medications 2.) Obtain any vitals needed for medication monitoring 3.) Perform hand hygiene 4.) Locate residents bubble packs and take them out of the cart 5.) Complete 5 rights of medication administration before popping out medications into the med cup. (do not touch the medications) <p>Review of Documentation of Verbal Warning dated 4/11/24 revealed Staff C, Licensed Practical Nurse (LPN) reported she had changed a residents medication order without obtaining an order first. You must get a doctors order to change the dosage of a medication before adjusting it. No longer tweak medications without obtaining an order first.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/25/24 at 8:54 AM the Director of Nursing stated the verbal warning for Staff C, LPN resulted from her entering Hospice orders for medication before the signed order from the physician was returned. For example when the Hospice nurse is here and we discuss medication changes and then she entered the order before the physician had signed the order. This only occurred one time I am aware of and I told her we can not do it. My expectations for administering medications is they follow the EMAR and they follow the rights of medication administration. Staff should not administer medication without a physician order.</p> <p>On 4/25/24 at 9:07 AM Staff D, Hospice Nurse, stated we collaborate with the facility nurse on appropriate medications and dosages and then contact the physician. The physician needs to agree to the recommendation for it to become an order.</p> <p>On 4/25/24 at 11:05 AM Staff C, LPN stated she did receive a verbal warning about when Hospice comes and they talk about different medications or dosages and then the physician will typically give us the order. I have put the order in the computer before the signed orders come back. The DON educated me to make sure the orders are the same and in case the physician would make a change in the order and also to make sure no mistakes were made writing the order.</p> <p>The facility provided an undated policy titled Receiving Physician Orders which stated Licensed nursing staff may take orders from a physician's office nurse for the attending physician. It is a legal procedure for a nurse to take a phone order from a physician's office nurse per Board of Nursing. The policy failed to address procedure for entering physicians orders into the computer for the medication administration record.</p>		