STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165509	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Alverno Health Care Facility	849 13th Avenue North Clinton, IA 52732

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45338 Based on observation, interview, and record review the facility failed to ensure a resident's transfer from chair to bed was completed in a safe manner for 1 of 3 residents observed for transfers (Resident #12). The facility reported a census of 91 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #12 dated 1/28/25 revealed the resident scored 99 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident was unable to complete the interview. Per this assessment, the resident was dependent for the following: to roll left to right, sit to lying, lying to sitting on the side of the bed, sit to stand, and chair/bed-to-chair transfer, and weighed 89 pounds. Review of the Care Plan dated 12/18/17 revealed, I have a self care deficit associated with need for assistance with ADLs (activities of daily living) R/T (related to) (advanced age and alzheimers dementia. The Care Plan did not specify the level of transfer assistance required for Resident #12. The Intervention Dated 12/18/17 revealed, Provide assistance as described on the resident summary to complete ADL tasks. Allow resident to complete as much as possible for self and then complete task to standard. Review of the Resident Summary modified 10/17/24 revealed, I am a two assist with transfers and ambulation. I use a Broda chair for mobility with staff assisting me. Please keep my foot pedals up when I am stationary. I may use a positioning bear as needed for repositioning to promote my independence. On 2/5/25 at 2:32 PM, Staff A, Licensed Practical Nurse (LPN) and Staff B, Certified Nursing Assistant (CNA) present in Resident #12's room. Resident #12 observed in a broda chair positioned next to the resident's bed, with broda chair next to the foot of the resident's bed and Resident #12 in the chair, which was facing the head of the bed. Staff removed a pillow, the resident's broda chair observed to not be locked, and the chair moved when Staff A and Staff B two person lifted the resident from the broda chair into bed. A gait belt not observed to be used for Resident #12's transfer. When providing cares, staff said usually had two people in as the resident was so contracted. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/25 at 10:56 AM, the Therapy Director explained the resident's transfer status would have been in the resident summary. When queried about two person assist, as seen in the resident's summary, the Therapy Director explained there would be two staff assisting, one on each side, especially for Resident #12 as not real active. Per the Therapy Director, they'd put a gait belt on [Resident #12], person on each side, and would give her a lift. When queried if staff should use a gait belt, the Therapy Director responded, absolutely. When queried if moving from broda chair to bed if the broda chair should be locked, the Therapy Director responded, absolutely. On 2/6/25 at 11:03 AM, Staff C, CNA queried about transfer status for the resident, and responded resident was 2 person pivot. When queried if the resident put their feet on the ground, Staff C responded, not really. When queried if during 2 person pivot if resident should have gait belt on, Staff C responded, yeah. When queried if going form broda chair to bed if the broda should be locked, Staff C responded, yeah. On 2/6/25 at 11:19 AM, Staff A, LPN, who was observed to assist with the resident's transfer on 2/5/25, queried if a gait belt used for the transfer. Staff A responded no. When queried if it should have been, Staff A responded the resident was 80 pounds and contracted, discussed positioning of a gait belt for the resident, and did not specify yes or no. When queried if the broda chair should have been locked for the transfer, Staff A acknowledged should have been, and could not remember if it had been. On 2/6/25 at 1:57 PM, the facility's Director of Nursing (DON) explained for two person transfer should have two staff members, gait belt, and then lock the chair, and have her stand pivot to the bed with walker if able to hold on to it. Review of the Facility Policy titled Accidents/Incidents or Unusual Occurence Reports (Skilled Nursing) dated May 2023 did not not address the area of concern.

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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** 45775 Based on observations, clinical record review, and staff interviews, the facility failed to ensure an insulin pens was primed and the medication administered prior to the expiration date for 1 of 2 residents reviewed for insulin administration (Resident #45). The facility reported a census of 91 residents. Findings include: The Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #45 had diagnosis of Diabetes Mellitus and received insulin injections on a daily basis. A review of the February 2025 MAR revealed an order, initiated [DATE], for Insulin Lispro 100 units per milliliter (mL) subcutaneous pen with instructions to administer sliding scale insulin three times a day as follows: For blood sugars between 70 and 150, give 0 units; ,d+[DATE], give 2 units; ,d+[DATE], give 4 units; ,d+[DATE], give 6 units; ,d+[DATE], give 8 units; ,d+[DATE], give 10 units; and ,d+[DATE], give 12 units. During an observation on [DATE] at 8:55 AM, Staff A, Licensed Practical Nurse (LPN), prepared Resident #45's Insulin Lispro pen at the medication cart. Staff A did not prime the insulin pen prior to the administration of 2 units for a blood sugar of 168. The Insulin Lispro pen observed to have a hand written open date of [DATE] on the storage bag and the pharmacy label. When queried, Staff A stated Resident #45's insulin Lispro pen did not need to be primed prior to administration. Staff A unable to identify how long the Lispro pen is good for after it is opened, and if or when the the insulin pen expired. During an interview on [DATE] at 2:47 PM, the Director of Nursing (DON), stated the insulin pen needed to be primed with 2 units prior to administration to prevent air from remaining in needle. The DON stated nursing staff needed to the check expiration date on insulin pens prior administration and if expired, they need to obtain a new insulin pen. During an interview on [DATE] at 3:27 PM, the DON confirmed Resident #45's Insulin Lispro pen had an opened date of [DATE] and stated that according to manufacturer's recommendations, the insulin pen expired 28 days after opened and should have been removed from medication cart on [DATE]. The DON reported Resident #45 Lispro insulin pen had been discarded. The facility provided a document titled Licensed Nurse Skill Competency Checklist, dated [DATE]. The checklist included a competency for licensed nursing staff to demonstrate how to prepare and give insulin injection and to demonstrate how to apply a needle to an insulin pen, dial and perform a two unit air shot, dial the insulin dose, and administer with an insulin pen. The checklist did not address the need to check the expiration date of an insulin pen.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072 Based on clinical record review, facility policy review and staff interview the facility failed to follow up on pharmacy recommendations for the monitoring of medications and gradual dose reduction for 4 out of 5 residents reviewed. (Residents #2, #20, #45, and #60) The facility identified a census of 91 residents. Findings include: 1. Review of the Minimum Data Set (MDS), dated [DATE] revealed Resident #20 scored 13 out of 15 on the Brief Interview for Mental Status, which indicated intact cognition. Per the assessment the resident took antidepressant, hypnotic, diuretic, opioid, and antiplatelet medications A review of Physician Orders revealed an order, dated 4/21/23 for duloxetine (an antidepressant) 30 mg (milligrams) 1 tab daily The Consultation report dated 11/25/24 revealed [Resident #20] has received duloxetine (Cymbalta) daily since 4/20/23. Recommendation: Please attempt a gradual dose reduction (GDR) of duloxetine to 20 mg daily. Review of Resident #20 Progress Notes revealed a lack of documentation about a GDR for duloxetine. A review of the February Medication Administration Record (MAR) revealed Resident #20 received the duloxetine 30 mg from 2/1/25 through 2/6/25. 2. A review of Physician Orders revealed an order for Resident #2 for lorazepam (antianxiety) 0.5 mg twice daily, state date 11/8/23. The Consultation Report dated 10/23/24 revealed [Resident #2] has received lorazepam 0.5 mg twice daily since 11/8/23. Recommendation: Please attempt a GDR of lorazepam 0.5 mg at bedtime. Review Resident #2 Progress Notes revealed a lack of documentation about a GDR for lorazepam. Review of the February 2025 MAR for Resident #2 revealed lorazepam 0.5 mg was administered 2/1/25 to 2/6/25. 45338 3. Review of the MDS dated [DATE] revealed Resident #45 scored 2 out of 15 on a BIMS exam, which indicated severely impaired cognition. Per this assessment, the resident took antidepressant, antianxiety, antipsychotic, opioid, antiplatelet, hypoglycemic, and anticonvulsant medication. The Physician Order dated 9/26/24 revealed the resident ordered fluoxetine 40 mg one time daily. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Consultation Report dated 7/23/24 revealed, [Resident #45] has received fluoxetine (Prozac) 40 mg (milligrams) daily since 9/21/22. Recommendation: Please attempt a gradual dose reduction (GDR) of fluoxetine to 30 mg daily. An option per the Physician Response section was left blank, and the Consultation Report was unsigned. Review of Resident #45's Progress Notes from 7/23/24 to 2/4/24 lacked documentation about a gradual dose reduction (GDR) for fluoxetine. Review of the Medication Administration Record (MAR) dated February 2025 revealed the resident received fluoxetine 40 mg from 2/1/25 though 2/6/25. 34821 4. The MDS assessment dated [DATE] revealed Resident #60 scored 13 out of 15 on the BIMS, which indicated intact cognition. The MDS list of diagnoses included depression. The Care Plan for Resident #60 dated 11/27/24, identified diagnoses of anxiety and depression, and the resident prescribed buspirone and venlafaxine (antidepressants). The Physician's Orders dated 2/6/25 listed medication orders that included: a. buspirone 5 milligrams (mg) two times daily started on 4/5/2024 (anxiety medication). b. venlafaxine extended release ER 150 mg (take with the 75 mg) started on 4/5/2024 (antidepressant medication). c. venlafaxine extended release ER 75 mg one time a day started on 4/5/2024. The Pharmacist Consultation Report dated 8/28/24, listed the names of 2 diuretic medication, furosemide 80 mg daily and Spironolactone 25 mg daily. He questioned to the Primary Care Provider (PCP) to complete a basic metabolic panel (BMP) blood draw on the next laboratory (lab) day and then every 6 months. The Pharmacist Consultation Report dated 10/24/24, reflected a question to the Primary Care Provider (PCP) to attempt a GDR of the buspirone 5 mg two times a day to 2.5 mg two times a day. The Pharmacist Consultation Report dated 12/20/24, identified Resident#60 took Spironolactone 25 mg daily, and potassium chloride 20 milliequivalent (mEq) daily. The Pharmacist explained the risks of the medication and requested laboratory monitoring. He asked the PCP to schedule a BMP on the next lab. The Pharmacist Consultation Report dated 1/20/25, questioned to the PCP to attempt a GDR of the buspirone 5 mg two times a day to 2.5 mg two times a day. The Clinical Notes for Resident #60 dated 8/28/24 through 2/6/25 failed to include documentation the Pharmacist recommendations were addressed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/06/25 at 9:40 AM, the Director of Nursing (DON) reported she took the DON job in May 2024. She revealed as the DON she received the emails form the Pharmacist and put them in a folder. She stated she failed to review the information and send the request to the PCP. Review of the facility policy, titled Medication Regimen Review, last revised on 6/1/24 revealed Procedures which included, in part: #8. The consultant pharmacist will provide the resident ' s MRRs (Medication Regimen Review) to facility identified personnel who will ensure that the attending physician, medical director, director of nursing and other necessary facility staff receive the recommendations. #13. The attending physician/prescriber should address the consultant pharmacist ' s recommendation no later than their next scheduled visit to the facility to assess the resident per facility policy, or applicable state and federal regulations.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072 Based on observation, food storage guidelines, and staff interviews the facility failed to label food, indicate the opened/prepared date of an item, and dispose of food kept beyond the expiration date in an effort to prevent prevent food borne illness. The facility reported a census of 91 residents. Findings include: During the initial kitchen tour on [DATE] at 9:45 AM, the following food items found in a refrigerator with either no label and or date opened, and kept beyond the expiration date: a. Large bag of lettuce in saran wrap, no open date indicated. b. Bag of french fries, no open date indicated. c. Melted butter, no prepared date indicated d. Corned beef, dated [DATE]. e. Zip lock bag with unknown contents, no date indicated. f. Dish of oatmeal, no prepared date indicated. g. Bread crumbs, no open date indicated. h. [NAME] beans with bacon, no prepared date indicated i. Cranberry salsa, dated [DATE] j. Three - 1 pound blocks of butter, no open date indicated. k. Bag of fried chicken, no open or prepared date indicated. l. Thawed chicken, no open or thraw date indicated. m. Pork roast, no open or prepared date indicated. n. Scrambled eggs, dated [DATE]. o. Chopped onions, dated [DATE]. The walk in refrigerator had the following items with expired dates on them: a. Sliced ham, dated [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Home made ranch dressing, dated [DATE]. During an interview on [DATE] at 1:00 PM Staff F, Sous Chef stated the kitchen uses the waste not program to dispose of outdated food. He explained it is a tracking program of food in refrigerator. Staff F explained food has various shelf life and we use first in first out method. He stated he, and the cooks are responsible for disposing of outdated foods. Staff F stated everything should be labeled with name, date opened and what it is. He stated the discard date should also be on the item. Staff F stated they have paperwork in the kitchen that tells you how long the food is good for once it has been opened. During an interview on [DATE] at 1:27 PM the Dietary Manager stated the expectation of staff for labeling food items, and it is actually on the cleaning list to check the refrigerators it is usually on 3 times per week. The Dietary Manager stated it would have been done on Friday and Monday and then again it should have gotten done. The Dietary Manager stated they would have expected those things to be labeled and dated. We usually have someone do a walk through on Sunday night. All items should be labeled and dated. The facility provided a document titled Refrigerated Storage Life of Foods dated [DATE] which directed: Use manufacturer's expiration date for products before they are opened. If there is no expiration date on the package, add the time listed here to the date the food is received. Add the time in the opened column to the date when the food is prepared or opened. Label when product is opened. The time listed is added to today's date. The document listed all types of foods and the amount of days to be added, for example: butter/margarine + 3 days, homemade salad dressings +7 days, and deli meat +3 days.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48888 Based on observations, clinical record review, nurse competency checklist and staff interviews, the facility failed to perform the infection control practices of hand hygiene and cleaning the hub of an insulin pen prior to the attachment of the needle for 2 of 2 residents reviewed for insulin administration (Resident #11 and Resident #45). The facility reported a census of 91 residents. Findings include: 1. The Minimum Data Set (MDS) assessment, dated 12/17/24, revealed Resident #11 had diagnosis of Type 2 Diabetes Mellitus and received insulin injections on a daily basis. A review of the February 2025 Medication Administration Record (MAR), revealed an order, initiated 7/18/24, for Insulin Lispro 100 units per milliliter (mL) subcutaneous pen with instructions to administer sliding scale insulin three times a day as follows:For blood sugars between 70 and 150, give 0 units; 151-200, give 2 units; 201-250, give 4 units; 251-300, give 6 units; 301-350, give 8 units; and 351-400, give 10 units. The MAR, dated February 2025, revealed an order, initiated 2/04/25, for Lantus Solostar Insulin 100 units/mL subcutaneous pen with instructions to inject 50 units every morning and 48 units every evening. During an observation on 2/06/25 at 8:20 AM, Staff H, Licensed Practical Nurse (LPN), prepared Resident #11's Insulin Lispro pen and Insulin Lantus pen at the medication cart. Staff H opened the insulin pen needles, packaged separately from the pen, and without cleaning the hub directly screwed the needle to the pens. Staff H then entered the residents room to administer the medication. Without donning gloves, Staff H cleaned the residents right upper inner thigh with an alcohol wipe and injected both Insulin Lispro and Insulin Lantus. Staff H applied hand sanitizer and exited resident room, insulin needles placed into sharps container kept on medication cart. During an interview on 2/06/25 at 08:30 AM, Staff H denied cleaning the hub of the insulin pens prior to needle attachment and stated she probably should have. Staff H denied wearing gloves to administer Resident #11's insulin and stated she would normally wear gloves when administering insulin injection. 2. The MDS assessment, dated 10/03/24, revealed Resident #45 had diagnosis of Diabetes Mellitus and received insulin injections on a daily basis. A review of the February 2025 MAR revealed an order, initiated 9/26/24, for Insulin Lispro 100 units per milliliter (mL) subcutaneous pen with instructions to administer sliding scale insulin three times a day as follows: For blood sugars between 70 and 150, give 0 units; 151-200, give 2 units; 201-250, give 4 units; 251-300, give 6 units; 301-350, give 8 units; 351-400, give 10 units; and 401-450, give 12 units. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/06/25 at 8:55 AM, Staff A, LPN, prepared Resident #45's Insulin Lispro pen at the medication cart. The insulin pen needles, packaged separately from pen, were opened and without cleaning the hub Staff A screwed the needle onto the insulin pen. During an interview on 2/06/25 at 1:35 PM, Staff I, Infection Preventionist stated the expectation is for the nurse to clean the hub of insulin pens prior to attaching needle. She added nursing staff are to wear gloves during administration of a resident's insulin injection in efforts to prevent infections. During an interview on 2/06/25 at 2:47 PM, the Director of Nursing stated she would expect the nursing staff to clean the hub of insulin pens with alcohol wipe prior to attaching the needle. She stated the staff should also perform hand hygiene and apply gloves before administering injections. A review of the document titled Licensed Nurse Skill Competency Checklist, dated 11/14/23, revealed competencies under the Glucometer section included, in part: Demonstrate how to prepare and give insulin injection and to demonstrate how to apply a needle to an insulin pen. A review of document titled Medication Pass Review, dated 10/01 under the Infection Control section revealed a competency related to Where universal precautions adhered to, including syringe disposal?