

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165530	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Glen Haven Village		STREET ADDRESS, CITY, STATE, ZIP CODE 133 Indian Hills Drive Glenwood, IA 51534	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interviews, facility investigation review and policy review the facility failed to ensure the residents were free of significant medication errors when medication were given to residents from another residents medication card and failure to prime an insulin pen to 6 of 8 residents reviewed (Resident #6, #32, #34, #9, #56 and #64). The facility reported a census of 65 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #6 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. Review of Resident #6's Electronic Health Record (EHR) titled, Orders documented no physician's order for alprazolam. 2. The MDS dated [DATE] revealed Resident #32 had a BIMS of 15 indicating no cognitive impairment. Resident #32's MDS also documented diagnoses of major depression and anxiety disorder. Review of Resident #32's EHR titled, Orders documented a physician's order for alprazolam 1mg take a half tablet (0.5mg) 3 times daily as needed. Review of Resident #32's document titled, Controlled Substance Administration Record documented a count for alprazolam 1mg take a half tablet (0.5mg) on 6/28/26 at 4:45 PM to be 12 tablets remaining. Review of Resident #32's document titled, Controlled Substance Administration Record documented a count for alprazolam 1mg take a half tablet (0.5mg) on 6/29/26 at 6:30 PM to be 10 tablets remaining with the count corrected by Staff I, Registered Nurse (RN). Review of a photo of Resident #32's medication card (bubble pack) for medication alprazolam 1mg take a half tablet (0.5mg) revealed 10 tablets remained. 3. The MDS dated [DATE] revealed Resident #34 had a BIMS of 2 indicating severe cognitive impairment. Review of Resident #34's EHR titled, Orders documented no physician's order for alprazolam. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of video footage from the evening of 6/28/26 to 6/29/26 revealed the following: At 12:18:54 AM Staff O walks into the unit and immediately opens the narcotics book and starts flipping pages. At 12:20:32 Staff O opens the narcotics drawer and begins removing medications, Staff O looks through the bubble packs. At 12:21:31 Staff O popped out 2 medications from the same bubble pack. Staff O went to the narcotic book, Staff O looked for a pen gasped, Staff O did not sign the narcotics book, Staff O looked at the watch flipped through the book, Staff O looked at the pages, flipped through pages of the book and did not sign anything, Staff O placed the medications in 2 different medications cups. Staff O explained she was getting the resident something, Staff O then stated If they don't calm down, call me. At 12:27:28 Staff O entered a resident's room with medications, Staff O asked the resident did you swallow it and the resident said yes. At 12:31:50 Staff O went to the next resident's room with the other medication cup in hand. Review of video footage from the over night of 6/28/26 to 6/29/26 revealed the following: At 12:33 AM Staff O entered Resident #6's room and stated I've got your anxiety medicine. Resident #6 asked what it is called, Staff O stated lorazepam, just a half of one; we're going to try 0.25 mg, a very little dose, Staff O stated we are going to try it because we need to, Staff O stated let's take a bite. Resident #6 stated I want to know where it came from. Staff O explained the doctor wrote an order for it and it is to start today. Staff O stated it's after midnight, you're still awake and we are going to try the medicine. Resident #6 stated I ain't got a new medication. Staff O explained this is the new one, Resident #6 states will you back down for a minute, Staff O stated you knew about this. You told me about it. At 12:34:20 AM Staff N, Certified Nursing Assistant (CNA) entered the room. Resident #6 said I can refuse it so I did not tell you about it. Which kind is it? Staff O stated this is your new lorazepam, that you're supposed to start taking to help you sleep especially at night, Resident #6 said what is the medication's other name, Staff O said I'll go get a print out for you. At 12:34:47 AM Staff O left the room. Staff N stated Staff O just told you what you're on, and it's after midnight, and you're wound tighter than I don't know what. The nurse is getting a print out. At 12:35:27 AM Staff O returned without anything in hand. Staff O stated so we can try this or we can try an injection. Do you want the injection, Resident #6 said no I don't need an injection. Staff O explained Lorazepam I'll write it down. I'm trying to give you the medicine the doctor ordered. At 12:36:52 AM Staff N left the room. Staff O stated Ma'am, Ma'am I have to get more printer paper; there is not enough to print off. Resident #6 stated I'm going to call my son. Staff O stated you're going to call your son at midnight? Okay, we're going to go through all this for a pill. It's midnight. I'm (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	going to go and I'm going to come back, ma'am. This is ridiculous. At 12:38:21 AM Staff O left the room with medication and a spoon in her left hand. Staff O stated (outside the room, down the hallway) Yeah, I'm going to have to try later (talking to Staff N at the end of the hall). At 12:41:15 AM Resident #6 stated the staff is upset I'm not taking the medication (on the phone with her son). On 7/8/26 at 2:04 PM Staff J, Registered Nurse (RN) / Care Coordinator stated she was called by the nurse that was coming on duty on 6/29/26 at 6:00 PM and Staff M RN called and told her the count was off by 2 tablets for alprazolam for Resident #32. Staff J asked if someone gave it and did not sign it out. Staff J stated Resident #32 had gone to the hospital so she did not get the medication. Staff J stated Staff K, RN and her counted the next morning and that was when she and Staff K started the investigation. Staff J explained that was when they found out if there was a documentation error. Staff J stated Staff L, Licensed Practical Nurse (LPN) completed the count the morning of 6/29/26. Staff J stated Staff L explained Staff O, LPN forgot to sign Resident #32's alprazolam out and the count was 10 tablets that morning. Staff J stated per the narcotics book the count was not correct. Staff J stated that was when it was left by Staff L and caught later that same day. Staff J explained the video was reviewed to determine where the medications went. Staff J stated that was when there was an observation of Staff O who gave an as needed (PRN) medication to Resident #6 and #34. Staff J stated she texted Staff O if she had given (PRN) alprazolam while she was at work. Staff J then opened her phone and read the text message back to the Surveyor. Stated I believe so and I can pick up a shift if needed. Staff J stated she then texted Staff O did you give the medication to someone who didn't have an order?. Staff J stated Staff O responded to the text with she did not believe so and she could fix it. On 7/8/26 at 2:21 PM Staff K, RN / Care Coordinator stated on the morning of 6/29/26 Staff M the oncoming nurse noticed Resident #32's alprazolam was off by 2 tablets. Staff K explained Staff L told her Staff O stated she needed to fill out the as needed alprazolam for Resident #32. Staff K explained Staff L thought Staff O corrected the narcotics count for Resident #32 but walked away and did not review it. Staff K explained the evening of 6/29/26 between shifts Staff L and Staff M RN realized Resident #32's alprazolam was off again by the same amount 2 they notified Staff J who was the nurse on call and Staff J and Staff L talked. Staff K explained that was when it was discovered Staff O had given 2 and needed to record them. Staff K stated Staff J instructed them to correct the count and would look further into the incident the following morning. Staff K explained the next morning she looked into the incident. Staff K stated that was when the video of the evening of 6/28/26 was reviewed and it was discovered Staff O had attempted to give Resident #6 and #34 Resident #32's PRN alprazolam. On 7/8/26 at 4:38 PM Staff L, LPN stated she counted with Staff O the morning of 6/29/26. Staff L stated she counted 4 houses (residential units) that day. Staff L stated Staff O was reading the narcotic book and Staff L was reading the medication cards. Staff L stated the count was off for Resident #32 and said something to Staff O and signed something out in the narcotics book, Staff L explained when Staff M came in at 6:00 PM she noticed the count was off for Resident #32. Staff L (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated Staff O just agreed with her and did not know if that was the same concern she had noticed. Staff L stated it looked like the count was right because Staff O was just agreeing with her when the count was completed. Staff L stated she would not have known what the difference was between the medication card and the narcotic book because she was looking at the medication card and Staff O was looking at the book and just agreeing. On 7/9/26 at 8:27 AM Staff M, RN stated she was the oncoming nurse at 6:00 PM - 10:00 PM on 6/29/26. Staff M explained the count was being completed and the count was not correct. Staff M explained Resident #32's alprazolam was off by 2 tablets. Staff M stated there were 10 and the narcotic count book documented 12 tablets. Staff M stated she pulled up the electronic medication administration record for Resident #32 to see when the medication was last given for Resident #32 and the time that was in the computer system as well as the time on the signed paper matched. Staff M stated that was when she knew there was a discrepancy. Staff M stated they did not find the medications anywhere and searched everywhere. Staff M explained Resident #32 had been sent out the morning of 6/29/26 at 9:00 AM. Staff M stated she fixed the count and called Staff J. Staff M explained Staff J said there was something else they were looking into that happened the night before. On 7/9/26 at 9:09 AM Staff N, Certified Nurse Assistant (CNA) stated she worked the overnight shift of 6/28/26. Staff N explained Resident #6 and #34 were very anxious. Staff N stated she asked Staff O if the residents had any Xanax or could she give the residents both something. Staff N stated Staff O put the medication in apple sauce or pudding. Staff N stated Staff O gave the medication to Resident #34 and came back out and said Resident #6 refused. On 7/10/26 at 12:59 PM Staff N stated she was scared to say anything but Staff O had her give the medication to Resident #34 because she had a better rapport. Stated she was just following the order from Staff O. Staff N stated Staff O had tried multiple times. Staff N explained she was scared to come out and say something because she was scared of what might happen. Staff N stated Staff O stayed in the hall when she gave the medication and could see her. Staff N stated Staff O was the RN and totally wanted the medications given and did not want it to come out later that a CNA gave the medication. Review of the document titled, 6.28.26 Abuse Investigation documented during the narcotic count at approximately 6:00 a.m. shift change on 6/29/26, with Nurses, Staff L, LPN and Staff O, LPN it was identified that the controlled substance count for Xanax (alprazolam) was incorrect, with two tablets unaccounted for. Staff O informed the oncoming nurse that she needed to document administration of two Xanax tablets she had reportedly given so that the narcotic count would be accurate. The oncoming nurse left the area, and Staff O did not complete the required documentation or reconcile the narcotic count. The discrepancy remained unresolved and was again identified during the 6:00 p.m. shift change. At that time the two nurses on duty notified Staff J, RN who escalated the concern for investigation. A subsequent investigation was conducted by Staff K, Care Coordinator for cottage 247, including review of facility camera footage, resident interviews, medication records, and interviews with staff members who were on duty. Based on the findings, it was determined that Staff O administered a Xanax tablet to another resident who did not have a current physician's order for the medication at approximately 12:20am on 6/29. The investigation also found that Staff O attempted to (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administer Xanax at approximately 12:35am to a second resident, who likewise did not have a physician's order; however, that resident refused the medication, preventing administration. Once these findings were noted, the Administrator was made aware immediately at approximately 1130am on Tuesday June 30th. On 7/7/26 at 12:33 PM the Administrator stated it was determined that Staff O removed the missing alprazolam from Resident #32's medication card and tried to administer the medications to 2 other residents. The Administrator stated one of the residents refused and the other resident took the medication. The Administrator stated Resident #32 was currently at the hospital and the facility would replace the 2 medications at the facility's expense. On 7/9/26 at 1:14 PM the Administrator stated she would like to have seen medications administered to the appropriated resident. 4.The MDS dated [DATE] documented Resident #9 had a BIMS of 15 indicating no cognitive impairment. Review of Resident #9's EHR titled, Order Summary Report documented a physician's order for Oxycodone 5 mg tablets to take 2 tablets (10 mg) by mouth every 4 hours as needed for pain. 5. The MDS dated [DATE] documented Resident #56 had a Brief Interview for Mental Status (BIMS) of 3 indicated severe cognitive impairment. Review of Resident #56's EHR titled, Order Summary Report documented a physician's order for Lantus Solos Injection 100/ml to inject 60 units subcutaneously daily for diagnosis of type 2 diabetes mellitus. Observation on 7/7/26 at 9:11 AM revealed Staff F, Registered Nurse (RN) assisted Resident #56 from the dining room table to a private room to administer insulin. Staff F, did not perform proper hand hygiene, applied gloves, applied needle to the tip of multidose insulin pen, failed to prime needle before dialing multidose pen to 60 units, cleansed abdomen with an alcohol swab and administered 60 units subcutaneously to Resident #56, gloves removed and hand hygiene performed. 6. The MDS dated [DATE] documented Resident #64 had a BIMS of 15 indicating no cognitive impairment. Review of Resident #64's EHR titled, Order Summary Report documented a physician's order for Oxycodone tablet 10 mg to take one tablet by mouth every four hours routinely for pain. Observation on 7/6/26 at 11:58 AM revealed Staff G, Certified Nurse Assistant/Certified Medication Assistant (CNA/CMA), performed hand hygiene and accessed the narcotic locked box to retrieve medications for Resident #64. Staff G removed two 5 mg Oxycodone medication cards, identified cards as Resident #64's and dispensed one 5 mg tablet from each card. When documenting the narcotic count, Staff G identified a discrepancy and requested assistance from Staff F Registered Nurse (RN). Staff F determined that Staff G had dispensed one 5 mg tablet from Resident #64's card (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and one 5 mg tablet from Resident #9's card. Staff G failed to verify the resident's identity against the medication cards prior to dispensing the medication. Staff F and another nurse destroyed the medication dispensed in error, and Staff G completed the administration of the correct 10 mg dose for Resident #64. Interview on 7/7/26 at 9:30 AM Staff F stated she does not prime any of her insulin pens before dialing the pen to the amount of units ordered before administering the insulin to any of her Residents. Interview on 7/8/26 at 12:12 PM the Director of Nursing (DON) stated he would expect to see the nurses prime every insulin needle with 2 units prior to dispensing the ordered units to the residents. Review of facility provided competency titled, Insulin Pen Competency provided to facility nurses for education documented the performance objective to wipe pen end with alcohol wipe; apply needle-Do not remove the cap turn dial at bottom of pen to a 2 and hold release button; release needle air and will have droplets of medication. Turn the dial to the correct number for correct dosage and verify the order of medication. Review of a facility provided policy Revised 7/6/26 titled, Medication Administration Policy and Procedure documented it was the policy of the facility to maintain a safe and competent medication management system that is based on best practice and the care process of the residents that includes: recognition of the problem/need, assessment, diagnosis (es), medication administration, management, monitoring and revising the individualized, person-centered approach to care as well as documentation consistent with standards of medication management and administration standards. The objective of the Medication Management Policy is to promote a safe and accurate medication management system for each individual resident, to ensure a system for accurate process of assessment, planning, implementation and monitoring/evaluation and staff competency to promote quality of care, increase resident safety and safeguard against adverse events. The attending physician, interdisciplinary team, resident and/or resident representative will plan approaches that include both medications and non-pharmacological interventions based upon the resident's individualized medical conditions, choices and needs. Behavioral interventions are individualized, non-pharmacological approaches to care that are provided as part of a supportive physical and psychosocial environment, directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities, as well as maintaining or improving a resident's mental, physical or psychosocial wellbeing. Medication Error: A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The facility has sufficient staff to allow administering of medications without unnecessary interruptions. Medications are administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medications. Medications are administered in accordance with written orders of the attending physician or physician extender. The person who prepares the dose for administration is the person who administers the dose.		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, facility investigation review, facility policy review and staff interviews the facility failed to protect a resident from misappropriation a resident's medications for 1 of 3 residents reviewed (Resident #32). The facility reported a census of 65 residents. Finding include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #32 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. Resident #32's MDS also documented diagnoses of major depression and anxiety disorder. Review of Resident #32's Electronic Health Record (EHR) titled, Orders documented a physician's order for alprazolam 1mg take a half tablet (0.5mg) 3 times daily as needed. Review of Resident #32's document titled, Controlled Substance Administration Record documented a count for alprazolam 1mg take a half tablet (0.5mg) on 6/28/26 at 4:45 PM to be 12 tablets remaining. Review of Resident #32's document titled, Controlled Substance Administration Record documented a count for alprazolam 1mg take a half tablet (0.5mg) on 6/29/26 at 6:30 PM to be 10 tablets remaining with the count corrected by Staff I, Registered Nurse (RN). Review of a photo of Resident #32's medication card (bubble pack) for medication alprazolam 1mg take a half tablet (0.5mg) revealed 10 tablets remained. Review of video footage from the evening of 6/28/26 to 6/29/26 revealed the following: At 12:18:54 AM Staff O walks into the unit and immediately opens the narcotics book and starts flipping pages. At 12:20:32 Staff O opens the narcotics drawer and begins removing medications, Staff O looks through the bubble packs. At 12:21:31 Staff O popped out 2 medications from the same bubble pack. Staff O went to the narcotic book, Staff O looked for a pen gasped, Staff O did not sign the narcotics book, Staff O looked at the watch flipped through the book, Staff O looked at the pages, flipped through pages of the book and did not sign anything, Staff O placed the medications in 2 different medications cups. Staff O explained she was getting the resident something, Staff O then stated If they don't calm down, call me. At 12:27:28 Staff O entered a resident's room with medications, Staff O asked the resident did you swallow it and the resident said yes. At 12:31:50 Staff O went to the next resident's room with the other medication cup in hand. On 7/8/26 at 2:04 PM Staff J, Registered Nurse (RN) / Care Coordinator stated she was called by the nurse that was coming on duty on 6/29/26 at 6:00 PM. Staff M RN called and told her the count was off by 2 tablets for alprazolam for Resident #32. Staff J asked if someone gave it and did not sign it out. Staff J stated Resident #32 had gone to the hospital so she did not get the medication. Staff J stated Staff K, RN and her counted the next morning and that was when she and Staff K started the investigation. Staff J explained that was when they found out if there was a documentation error. Staff J stated Staff L, Licensed Practical Nurse (LPN) completed the count the morning of 6/29/26. Staff J stated Staff L explained Staff O, LPN forgot to sign Resident #32's alprazolam out and the count was 10 tablets that morning. Staff J stated per the narcotics book the count was not correct. Staff J stated that was when it was left by Staff L and caught later that same day. Staff J explained the video was reviewed to determine where the medications went. Staff J stated that was when there was an observation of Staff O who gave an as needed (PRN) medication to 2 other residents. Staff J stated she texted Staff O if she had given (PRN) alprazolam while she was at work. Staff J then opened her phone and read the text message back to the Surveyor. Stated I believe so and I can pick up a shift if needed. Staff J stated she then texted Staff O did you give the medication to someone who didn't have an order?. Staff J stated Staff O responded to the text with she did not believe so and she could fix it. On 7/8/26 at 2:21 PM Staff K, RN / Care Coordinator stated on the morning of 6/29/26 Staff M the oncoming nurse noticed Resident #32's alprazolam was (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	off by 2 tablets. Staff K explained Staff L told her Staff O stated she needed to fill out the as needed alprazolam for Resident #32. Staff K explained Staff L thought Staff O corrected the narcotics count for Resident #32 but walked away and did not review it. Staff K explained the evening of 6/29/26 between shifts Staff L and Staff M RN realized Resident #32's alprazolam was off again by the same amount of 2, they notified Staff J who was the nurse on call and Staff J and Staff L talked. Staff K explained that was when it was discovered Staff O had given 2 and needed to record them. Staff K stated Staff J instructed them to correct the count and would look further into the incident the following morning. Staff K explained the next morning she looked into the incident. Staff K stated that was when the video of the evening of 6/28/26 was reviewed and it was discovered Staff O had attempted to give 2 residents Resident #32's PRN alprazolam. On 7/8/26 at 4:38 PM Staff L, LPN stated she counted with Staff O the morning of 6/29/26. Staff L stated she counted 4 houses (residential units) that day. Staff L stated Staff O was reading the narcotic book and Staff L was reading the medication cards. Staff L stated the count was off for Resident #32 and said something to Staff O and signed something out in the narcotics book, Staff L explained when Staff M came in at 6:00 PM she noticed the count was off for Resident #32. Staff L stated Staff O just agreed with her and did not know if that was the same concern she had noticed. Staff L stated it looked like the count was right because Staff O was just agreeing with her when the count was completed. Staff L stated she would not have known what the difference was between the medication card and the narcotic book because she was looking at the medication card and Staff O was looking at the book and just agreeing. On 7/9/26 at 8:27 AM Staff M, RN stated she was the oncoming nurse at 6:00 PM - 10:00 PM on 6/29/26. Staff M explained the count was being completed and the count was not correct. Staff M explained Resident #32's alprazolam was off by 2 tablets. Staff M stated there were 10 and the narcotic count book documented 12 tablets. Staff M stated she pulled up the electronic medication administration record for Resident #32 to see when the medication was last given for Resident #32 and the time that was in the computer system as well as the time on the signed paper matched. Staff M stated that was when she knew there was a discrepancy. Staff M stated they did not find the medications anywhere and searched everywhere. Staff M explained Resident #32 had been sent out the morning of 6/29/26 at 9:00 AM. Staff M stated she fixed the count and called Staff J. Staff M explained Staff J said there was something else they were looking into that happened the night before. On 7/9/26 at 9:09 AM Staff N, Certified Nurse Assistant (CNA) stated she worked the overnight shift of 6/28/26. Staff N explained there were 2 residents that were very anxious. Staff N stated she asked Staff O if the residents had any Xanax or could she give the residents both something. Staff N stated Staff O put the medication in apple sauce or pudding. Staff N stated Staff O gave the medication to one of the residents and came back out and said she would give the other one to the other resident. Review of the documents titled, 6.28.26 Abuse Investigation documented during the narcotic count at approximately 6:00 a.m. shift change on 6/29/26, with Nurses, Staff L, LPN and Staff O, LPN it was identified that the controlled substance count for Xanax (alprazolam) was incorrect, with two tablets unaccounted for. Staff O informed the oncoming nurse that she needed to document administration of two Xanax tablets she had reportedly given so that the narcotic count would be accurate. The oncoming nurse left the area, and Staff O did not complete the required documentation or reconcile the narcotic count. The discrepancy remained unresolved and was again identified during the 6:00 p.m. shift change. At that time the two nurses on duty notified Staff J, RN who escalated the concern for investigation. A subsequent investigation was conducted by Staff K, Care Coordinator for cottage 247, including review of facility camera footage, resident interviews, medication records, and interviews with staff members who were on duty. Based on the findings, it (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Glen Haven Village		STREET ADDRESS, CITY, STATE, ZIP CODE 133 Indian Hills Drive Glenwood, IA 51534	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was determined that Staff O administered a Xanax tablet to another resident who did not have a current physician's order for the medication at approximately 12:20am on 6/29. The investigation also found that Staff O attempted to administer Xanax at approximately 12:35am to a second resident, who likewise did not have a physician's order; however, that resident refused the medication, preventing administration. Once these findings were noted, the Administrator was made aware immediately at approximately 1130am on Tuesday June 30th. On 7/7/26 at 12:33 PM the Administrator stated it was determined that Staff O removed the missing alprazolam from Resident #32's medication card and tried to administer the medications to 2 other residents. The Administrator stated one of the residents refused and the other resident took the medication. The Administrator stated Resident #32 was currently at the hospital and the facility would replace the 2 medications at the facility's expense. Review of facility provided policy revised 6/2/23 titled, Abuse and Neglect documented that all Residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and/or recordings on social media or through multimedia messages. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation and misappropriation of resident property. Any of the following as a result of the willful misconduct or gross negligence or reckless acts or omissions of a caretaker, taking into account the totality of the circumstances. Misappropriation of Resident property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a Resident's belongings or money without the Resident's consent.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview, facility investigation review, and facility policy review the facility staff administered psychotropic medications without an order to residents who were up at night to sedate them for 2 out of 7 residents reviewed (Resident #6, and #34). The facility also failed to have a duration or rationale for a resident with a psychotropic medication (Resident #8). The facility reported a census of 65 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #6 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. Review of Resident #6's Electronic Health Record (EHR) titled, Orders documented no physician's order for alprazolam. 2. The MDS dated [DATE] revealed Resident #34 had a BIMS of 2 indicating severe cognitive impairment. Review of Resident #34's EHR titled, Orders documented no physician's order for alprazolam. Review of video footage from the evening of 6/28/26 to 6/29/26 revealed the following: At 12:18:54 AM Staff O walks into the unit and immediately opens the narcotics book and starts flipping pages. At 12:20:32 Staff O opens the narcotics drawer and begins removing medications, Staff O looks through the bubble packs. At 12:21:31 Staff O popped out 2 medications from the same bubble pack. Staff O went to the narcotic book, Staff O looked for a pen gasped, Staff O did not sign the narcotics book, Staff O looked at the watch flipped through the book, Staff O looked at the pages, flipped through pages of the book and did not sign anything, Staff O placed the medications in 2 different medications cups. Staff O explained she was getting the resident something, Staff O then stated If they don't calm down, call me. At 12:27:28 Staff O entered a resident's room with medications, Staff O asked the resident did you swallow it and the resident said yes. At 12:31:50 Staff O went to the next resident's room with the other medication cup in hand. Review of video footage from the over night of 6/28/26 to 6/29/26 revealed the following: At 12:33 AM Staff O entered Resident #6's room and stated I've got your anxiety medicine. Resident #6 asked what it is called, Staff O stated lorazepam, just a half of one; we're going to try 0.25 mg, a very little dose, Staff O stated we are going to try it because we need to, Staff O stated let's take a (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bite. Resident #6 stated I want to know where it came from. Staff O explained the doctor wrote an order for it and it is to start today. Staff O stated it's after midnight, you're still awake and we are going to try the medicine. Resident #6 stated I ain't got a new medication. Staff O explained this is the new one, Resident #6 states will you back down for a minute, Staff O stated you knew about this. You told me about it. At 12:34:20 AM Staff N, Certified Nursing Assistant (CNA) entered the room. Resident #6 said I can refuse it so I did not tell you about it. Which kind is it? Staff O stated this is your new lorazepam, that you're supposed to start taking to help you sleep especially at night, Resident #6 said what is the medication's other name, Staff O said I'll go get a print out for you. At 12:34:47 AM Staff O left the room. Staff N stated Staff O just told you what you're on, and it's after midnight, and you're wound tighter than I don't know what. The nurse is getting a print out. At 12:35:27 AM Staff O returned without anything in hand. Staff O stated so we can try this or we can try an injection. Do you want the injection, Resident #6 said no I don't need an injection. Staff O explained Lorazepam I'll write it down. I'm trying to give you the medicine the doctor ordered. At 12:36:52 AM Staff N left the room. Staff O stated Ma'am, Ma'am I have to get more printer paper; there is not enough to print off. Resident #6 stated I'm going to call my son. Staff O stated you're going to call your son at midnight? Okay, we're going to go through all this for a pill. It's midnight. I'm going to go and I'm going to come back, ma'am. This is ridiculous. At 12:38:21 AM Staff O left the room with medication and a spoon in her left hand. Staff O stated (outside the room, down the hallway) Yeah, I'm going to have to try later (talking to Staff N at the end of the hall). At 12:41:15 AM Resident #6 stated the staff is upset I'm not taking the medication (on the phone with her son). Review of Resident #32's document titled, Controlled Substance Administration Record documented a count for alprazolam 1mg take a half tablet (0.5mg) on 6/28/26 at 4:45 PM to be 12 tablets remaining. Review of Resident #32's document titled, Controlled Substance Administration Record documented a count for alprazolam 1mg take a half tablet (0.5mg) on 6/29/26 at 6:30 PM to be 10 tablets remaining with the count corrected by Staff I, Registered Nurse (RN). Review of a photo of Resident #32's medication card (bubble pack) for medication alprazolam 1mg take a half tablet (0.5mg) revealed 10 tablets remained. On 7/8/26 at 2:04 PM Staff J, Registered Nurse (RN) / Care Coordinator stated she was called by the nurse that was coming on duty on 6/29/26 at 6:00 PM at Staff M RN called and told her the count was off by 2 tablets for alprazolam for Resident #32. Staff J asked if someone gave it and did not sign it out. Staff J stated Resident #32 had gone to the hospital so she did not get the medication. Staff J stated Staff K, RN and her counted the next morning and that was when she and Staff K started the (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation. Staff J explained that was when they found out if there was a documentation error. Staff J stated Staff L, Licensed Practical Nurse (LPN) completed the count the morning of 6/29/26. Staff J stated Staff L explained Staff O, LPN forgot to sign Resident #32's alprazolam out and the count was 10 tablets that morning. Staff J stated per the narcotics book the count was not correct. Staff J stated that was when it was left by Staff L and caught later that same day. Staff J explained the video was reviewed to determine where the medications went. Staff J stated that was when there was an observation of Staff O who gave an as needed (PRN) medication to Resident #6 and #34. Staff J stated she texted Staff O if she had given (PRN) alprazolam while she was at work. Staff J then opened her phone and read the text message back to the Surveyor. Stated I believe so and I can pick up a shift if needed. Staff J stated she then texted Staff O did you give the medication to someone who didn't have an order?. Staff J stated Staff O responded to the text with she did not believe so and she could fix it. On 7/8/26 at 2:21 PM Staff K, RN / Care Coordinator stated on the morning of 6/29/26 Staff M the oncoming nurse noticed Resident #32's alprazolam was off by 2 tablets. Staff K explained Staff L told her Staff O stated she needed to fill out the as needed alprazolam for Resident #32. Staff K explained Staff L thought Staff O corrected the narcotics count for Resident #32 but walked away and did not review it. Staff K explained the evening of 6/29/26 between shifts, Staff L and Staff M RN realized Resident #32's alprazolam was off again by the same amount of 2, they notified Staff J who was the nurse on call and Staff J and Staff L talked. Staff K explained that was when it was discovered Staff O had given 2 and needed to record them. Staff K stated Staff J instructed them to correct the count and would look further into the incident the following morning. Staff K explained the next morning she looked into the incident. Staff K stated that was when the video of the evening of 6/28/26 was reviewed and it was discovered Staff O had attempted to give Resident #6 and #34 Resident #32's PRN alprazolam. On 7/9/26 at 9:09 AM Staff N, Certified Nurse Assistant (CNA) stated she worked the overnight shift of 6/28/26. Staff N explained Resident #6 and #34 were very anxious. Staff N stated she asked Staff O if the residents had any xanax or could she give the residents both something. Staff N stated Staff O put the medication in apple sauce or pudding. Staff N stated Staff O gave the medication to Resident #34 and came back out and said Resident #6 refused. Staff N stated Staff O gave the medication to Resident #34 and came back out and said she would give that one to Resident #6. Staff N stated Resident #6 refused the medication and wanted the paper work. Staff N stated Resident #6 continued to refuse and the medication was not given. Staff N stated she went in the room with Resident #34 and watched Resident #34 get the medication from Staff O. Staff N stated Resident #34 said at first she was not going to take it and she did not need that. Staff N explained Staff O told her something else like it was for her health or something and appeared she was trying to give the medication anyway she could but did not say it was for anxiety. Staff N stated Staff O had her come out of Resident #34's room and had her help convince her to take the medication. Staff N stated Staff O told her when Resident #34 refused to not start fighting with her and Resident #34 said I'm not taking that. Staff N stated Resident #34 said you can't make me take that and said I'm going to call my husband. Staff N stated as soon as Resident #34 opened her mouth that Staff O shoved the medication in her mouth in the middle of the conversation. Staff N said then they left the room and Staff O was like I'm going to Resident #6's room to give her some medication. Staff N stated she told Resident #6 that her anxiety was through the roof and that would help assuming the nurse knew what (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was doing. Staff N explained Staff O argued with Resident #6 and Resident #6 was arguing back. Staff N stated Resident #6 requested the other name of the medication because she didn't take that. Staff N stated Resident #6 wanted to call her son and then did call her son. Staff N stated Staff O said if you want we can give you an injection to Resident #6. Staff N stated Resident #6 did not want an injection or the pill. Staff N stated Staff O said she would print the order but never did. Staff N stated Staff O told Resident #6 that it was ordered and the other name was lorazepam. Staff N stated the interaction made her uncomfortable and left the room before the nurse left. Staff N explained she never felt Staff O's actions crossed into abuse or that she should have notified the supervisor. Staff N stated Staff O seemed very deceptive when administering both Resident #6 and #34's medications. On 7/10/26 at 12:59 PM Staff N stated she was scared to say anything but Staff O had her give the medication to Resident #34 because she had a better rapport. Stated she was just following the order from Staff O. Staff N stated Staff O had tried multiple times. Staff N explained she was scared to come out and say something because she was scared of what might happen. Staff N stated Staff O stayed in the hall when she gave the medication and could see her. Staff N stated Staff O was the RN and totally wanted the medications given and did not want it to come out later that a CNA gave the medication. Review of document titled, 6.28.26 Abuse Investigation documented during the narcotic count at approximately 6:00 a.m. shift change on 6/29/26, with Nurses, Staff L, LPN and Staff O, LPN it was identified that the controlled substance count for Xanax (alprazolam) was incorrect, with two tablets unaccounted for. Staff O informed the oncoming nurse that she needed to document administration of two Xanax tablets she had reportedly given so that the narcotic count would be accurate. The oncoming nurse left the area, and Staff O did not complete the required documentation or reconcile the narcotic count. The discrepancy remained unresolved and was again identified during the 6:00 p.m. shift change. At that time the two nurses on duty notified Staff J, RN who escalated the concern for investigation. A subsequent investigation was conducted by Staff K, Care Coordinator for cottage 247, including review of facility camera footage, resident interviews, medication records, and interviews with staff members who were on duty. Based on the findings, it was determined that Staff O administered a Xanax tablet to another resident who did not have a current physician's order for the medication at approximately 12:20am on 6/29. The investigation also found that Staff O attempted to administer Xanax at approximately 12:35am to a second resident, who likewise did not have a physician's order; however, that resident refused the medication, preventing administration. Once these findings were noted, the Administrator was made aware immediately at approximately 1130am on Tuesday June 30th. On 7/7/26 at 12:33 PM the Administrator stated it was determined that Staff O removed the missing alprazolam from Resident #32's medication card and tried to administer the medications to Resident #6 and #34. The Administrator stated Resident #6 refused and Resident #34 took the medication. On 7/9/26 at 1:14 PM the Administrator stated she would like to have seen medications administered to the appropriate resident. 3. Review of Resident #8's MDS dated [DATE] revealed a readmission to the facility on 3-14-26 from a short-term general hospital stay. The MDS further indicated Resident #8 utilized antianxiety (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication during the seven day look back period. Review of the EHR page titled, Clinical Physician Orders revealed an order for Lorazepam 0.5mg to give 1/2 tablet (0.25mg) by mouth every 4 hours PRN (as needed) for anxiety. Further review of this order revealed that it was ordered on 6/4/26 with no end date. Review of Resident #8s June MAR revealed that as needed Lorazepam was given the 27th, 28th, and 29th. Review of Resident #8's July MAR revealed that as needed Lorazepam was given on the 1st of the month. Interview 7/07/26 at 1:00 PM with Staff H LPN/Care Coordinator confirmed the order for the PRN Lorazepam was ordered on 6/4/26, and further confirmed that there was no end date specified for the medication. Interview 7/07/26 at 1:11 PM with the DON revealed that the facility was going to send a clarification for a stop date for the Lorazepam that is used as necessary. The DON further revealed that Lorazepam should have an end date, and be reviewed by the physician. Review of a facility provided document titled, Psychotropic Care Plan Worksheet with a created date of 1/1/23 indicates that if the resident has a PRN psychotropic medication does the facility have an order to continue the medication with a duration and rationale? Review of facility provided policy revised 6/2/23 titled, Abuse and Neglect documented that all Residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and/or recordings on social media or through multimedia messages. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation and misappropriation of resident property. Any of the following as a result of the willful misconduct or gross negligence or reckless acts or omissions of a caretaker, taking into account the totality of the circumstances Neglect of a dependent adult. Neglect of a dependent adult means deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a dependent adult's life or physical or mental health.		