

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165602	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER Prestige Care Center of Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Highland Street Fairfield, IA 52556	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506</p> <p>S483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation</p> <p>Based on clinical record review, facility policy and staff interview, the facility failed to complete shift change controlled substance counts with the required two licensed nurses per facility policy. The facility reported census was 65.</p> <p>Findings include:</p> <p>According to Controlled Substance Administration and Accountability policy: 9. Inventory Verification b. Two licensed nurses account for all controlled substance and access keys at the end of each shift.</p> <p>In an interview on 8/19/24 at 2:15 p.m. Staff C, Certified Medication Aide, stated she worked 2:00 p.m. to 10:00 p.m. on 7/9/24 and was responsible for passing medications on [NAME] hall. Staff C stated at 2:00 p.m. she completed the narcotic count with Staff G, Registered Nurse, and all narcotics were accounted for and the medication cart keys were passed on to Staff C. Staff C stated at the end of her shift (10:00 p.m.) she attempted several times to contact the over night nurse to complete the narcotic count. After no response, Staff C stated she counted the narcotics on her own, noting all narcotics were accounted for and signing the Correct Count Verification form. Staff C then placed her medication cart keys in an unlocked drawer at the nurse's station in the presence of two aides, and left. Staff C stated counting narcotics on your own at the facility is a common practice. Medication cart keys are also often placed in a drawer at the nurse's station or in the narcotic book.</p> <p>In an interview on 8/20/24 at 6:30 a.m. Staff B, Certified Nurse Aide, stated she worked 10:00 p.m. to 6:00 a.m. on 7/9/24. Staff B stated Staff C was anxious to leave that evening. She told Staff A, Certified Nurse Aide, who was sitting at the nurse's station to open the desk drawer, then threw the medication cart keys into the drawer and left. Staff B stated at around 10:30 p.m. she went to her car to get some popcorn and when she returned, Staff A had two drawers open on the medication cart and was rummaging through the cards. The medication keys were around his wrist. Staff A quickly shut the drawers and placed the keys in his pocket when he saw Staff B.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165602	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER Prestige Care Center of Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Highland Street Fairfield, IA 52556	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 8/20/24 at 6:08 a.m. Staff D, Registered Nurse, stated she was working 10:00 p.m. to 6:00 a.m. on 7/9/24. Upon arriving at 9:45 p.m. she started off on [NAME], but immediately was told Staff F wanted her on Bonnifield hall. Staff D stated he was going home and she would be the only nurse in the building that evening. Staff D stated she counted narcotics on Bonnifield by her self. Staff D stated she then went to [NAME] hall and offered to count. Staff J, Registered Nurse, stated she had already counted. Staff D stated she passed some medications and answered a call light, then counted the narcotics on her own. At around 11:30 p.m. Staff D went to [NAME] hall and upon arriving asked where the keys were. Staff A pulled the keys out of the nurse's station drawer and handed them to Staff D. Staff D stated she did not count the narcotics. Staff D stated later that morning while on [NAME], she handed the medication cart keys to Staff K, Licensed Practical Nurse, without counting the narcotics per policy. Staff D stated she later received a call from Staff B regarding missing narcotics on [NAME].</p> <p>In an interview on 8/19/24 at 11:29 a.m. Staff E, Certified Medication Aide, stated she was working 6:00 a.m. to 2:00 p.m. on 7/10/24 and assigned to pass medications on [NAME] hall. The over night nurse was still upstairs, but the medication cart keys were left in the narcotic book. Staff E stated at 6:30 a.m. she began counting narcotics on her own and upon removing the first bubble pack belonging to Resident #2, she noticed two tablets of Hydrocodone/APAP 5-325 milligrams were missing from her supply. Staff E immediately called Staff D, the over night charge nurse and reported her findings. Staff E then continued to count narcotics on her own and pulled out a bubble pack belonging to Resident #1, this time noting a dose of Morphine sulfate 15 milligrams was missing. Staff E stated she called Staff D again and this time the Administrator and Director of Nursing were also notified. Staff E stated she continued to count the narcotics on her own and found no other missing narcotics. Staff E stated later that evening, at shift change, she and Staff F, Licensed Practical Nurse counted narcotics and discovered an entire bubble pack of 30 doses of Oxycodone 15 milligrams was missing from Resident #1's supply.</p> <p>According to the Correct Count Verification form for [NAME], on 7/9/24, 11-7 shift change, Staff J and Staff D both signed the count was correct, but failed to complete the count together per facility protocol.</p> <p>According to the Correct Count Verification form for [NAME], on 7/9/24, 11-7 shift change, Staff C signed the count was correct, but failed to complete the count with a second qualified person per facility protocol.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165602	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER Prestige Care Center of Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Highland Street Fairfield, IA 52556	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22506</p> <p>S483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>Based on clinical record review, facility policy and staff interview, the facility failed to ensure custody of medication cart keys were only accessible to authorized personnel. The facility reported census was 65.</p> <p>Findings include:</p> <p>According to Controlled Substance Administration and Accountability policy: 9. Inventory Verification b. Two licensed nurses account for all controlled substance and access keys at the end of each shift.</p> <p>In an interview on 8/19/24 at 2:15 p.m. Staff C, Certified Medication Aide, stated she worked 2:00 p.m. to 10:00 p.m. on 7/9/24 and was responsible for passing medications on [NAME] hall. Staff C stated at 2:00 p.m. she completed the narcotic count with Staff G, Registered Nurse, and all narcotics were accounted for and the medication cart keys were passed on to Staff C. Staff C stated at the end of her shift (10:00 p.m.) she attempted several times to contact the over night nurse to complete the narcotic count. After no response, Staff C stated she counted the narcotics on her own, noting all narcotics were accounted for and signing the Correct Count Verification form. Staff C then placed her medication cart keys in an unlocked drawer at the nurse's station in the presence of two aides, and left. Staff C stated counting narcotics on your own at the facility is a common practice. Medication cart keys are also often placed in a drawer at the nurse's station or in the narcotic book.</p> <p>In an interview on 8/20/24 at 6:30 a.m. Staff B, Certified Nurse Aide, stated she worked 10:00 p.m. to 6:00 a.m. on 7/9/24. Staff B stated Staff C was anxious to leave that evening. She told Staff A, Certified Nurse Aide, who was sitting at the nurse's station to open the desk drawer, then threw the medication cart keys into the drawer and left. Staff B stated at around 10:30 p.m. she went to her car to get some popcorn and when she returned, Staff A had two drawers open on the medication cart and was rummaging through the cards. The medication keys were around his wrist. Staff A quickly shut the drawers and placed the keys in his pocket when he saw Staff B.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165602	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER Prestige Care Center of Fairfield		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Highland Street Fairfield, IA 52556	
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 8/20/24 at 6:08 a.m. Staff D, Registered Nurse, stated she was working 10:00 p.m. to 6:00 a.m. on 7/9/24. Upon arriving at 9:45 p.m. she started off on [NAME], but immediately was told Staff F wanted her on Bonnifield hall. Staff D stated he was going home and she would be the only nurse in the building that evening. Staff D stated she counted narcotics on Bonnifield by her self. Staff D stated she then went to [NAME] hall and offered to count. Staff J, Registered Nurse, stated she had already counted. Staff D stated she passed some medications and answered a call light, then counted the narcotics on her own. At around 11:30 p.m. Staff D went to [NAME] hall and upon arriving asked where the keys were. Staff A pulled the keys out of the nurse's station drawer and handed them to Staff D. Staff D stated she did not count the narcotics. Staff D stated later that morning while on [NAME], she handed the medication cart keys to Staff K, Licensed Practical Nurse, without counting the narcotics per policy. Staff D stated she later received a call from Staff B regarding missing narcotics on [NAME].</p> <p>In an interview on 8/19/24 at 11:29 a.m. Staff E, Certified Medication Aide, stated she was working 6:00 a.m. to 2:00 p.m. on 7/10/24 and assigned to pass medications on [NAME] hall. The over night nurse was still upstairs, but the medication cart keys were left in the narcotic book. Staff E stated at 6:30 a.m. she began counting narcotics on her own and upon removing the first bubble pack belonging to Resident #2, she noticed two tablets of Hydrocodone/APAP 5-325 milligrams were missing from her supply. Staff E immediately called Staff D, the over night charge nurse and reported her findings. Staff E then continued to count narcotics on her own and pulled out a bubble pack belonging to Resident #1, this time noting a dose of Morphine sulfate 15 milligrams was missing. Staff E stated she called Staff D again and this time the Administrator and Director of Nursing were also notified. Staff E stated she continued to count the narcotics on her own and found no other missing narcotics. Staff E stated later that evening, at shift change, she and Staff F, Licensed Practical Nurse counted narcotics and discovered an entire bubble pack of 30 doses of Oxycodone 15 milligrams was missing from Resident #1's supply.</p>		