

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Walnut Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 1703 Campus Drive Clive, IA 50325	

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 - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>50471</p> <p>Based on observation, clinical record review, staff interview, and facility policy review, the facility failed to clarify the Doctor's order resulting in the medication error for 1 of 7 residents reviewed for medication administration (Resident #22). The facility reported a census of 35 residents.</p> <p>Findings include:</p> <p>On 8/7/24 at 8:30 AM Staff E, LPN reviewed the Electronic Medication Administration Record (EMAR) as she prepared the scheduled AM medication, including Senna S 50mg-8.6mg two tablets. The staff member placed the tablets in the medication cup looked over the tablets, reviewed the EMAR, then administered the tablets to the resident, including Senna S 50mg-8.6mg two tablets. The staff reviewed the EMAR and signed the administered medication, Senna S 50mg-8.6mg two tablets was administered.</p> <p>The EMAR dated 8/7/24 revealed Senna 8.6mg give two tablet by mouth two times a day for constipation, order date 1/25/23.</p> <p>On 8/7/24 at 2:40 PM Staff C, RN removed medication card from medication cart, verified the medication card, Senna S 50mg 8.6mg two tablets. Staff revealed the EMAR states Senna 8.6mg give two tablets by mouth two times a day for constipation, ordered on 1/25/23. The medication card delivered from pharmacy on 7/25/24. The staff spoke with the pharmacy, revealed the pharmacy stated order obtained 1/25/23 for increase.</p> <p>The Progress Noted 1/25/23 at 9:56 AM revealed telephone order received per the physician, increase resident's senna 8.6 to two tabs twice a day related to constipation. Medication administration record amended, pharmacy faxed, 24 hour sheet updated, resident and family aware, old cards pulled from cart.</p> <p>The Admission orders to the facility, 10/22/22, revealed order for Senna-S 50mg 8.6mg one tablet by mouth twice a day for constipation.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/8/24 at 9:50 AM Clinical Administrator revealed written telephone order, increase senna 8.6 mg two tabs twice a day (BID). The staff stated the resident was not on Senna, upon admission 10/22/22, the resident was ordered Senna-S one tablet by mouth twice a day. The staff stated when the nurse took the order it should have been increase of Senna-S from one tablet to two tablet by mouth twice a day for constipation. The nurse should have reviewed the order that was discontinued, realize it was not the same medication, call the Doctor to clarify the order.</p> <p>The facility policy titled Medication Administration Policy modified 5/21 instructed staff to ensure safe, effective and timely drug therapy, to provide for an accurate and concise documentation system. The staff will administer medications as ordered by the attending Physician/Nurse Practitioner. The 8 rights of drug administration will be followed when administering all medication: right resident, right drug, right dose, right dosage form, right route, right time, right reason, and right documentation. Accurate transcription of medication orders is the responsibility of licensed nursing staff.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50471</p> <p>Based on observations, staff interviews, the 2022 Food and Drug Administration (FDA) Food Code, and facility policy review, the facility failed to maintain sanitary practices by improperly storing food and failed to follow guidelines for checking the sanitizer parts per million (ppm) for 2 of 2 meals observed. The facility reported a census of 35 residents.</p> <p>Findings include:</p> <p>1. On 8/5/24 at 10:36 AM, Dietary Manager (DM), during initial walk through, the following was observed:</p> <p>In the Refrigerator #4, the following items did not have open date label: Prune juice, gallon of skim milk, gallon of 2% milk. A clear container with red lid had light red creamy liquid contents did not have a label for identification or date. The following items were not fully covered, cottage cheese and coleslaw.</p> <p>In the Refrigerator #3, the following item were not fully covered or dated, American cheese.</p> <p>In the Freezer, the following items were not covered, has brown and loaf of gluten bread.</p> <p>2. On 8/07/24 12:25 PM DM revealed they have not been checking the sanitizer concentration for ppm. The staff member revealed that task should be completed however the dietary staff have not done it since she started (9/19/22). The staff unable to provide any documentation of when the sanitizer concentration was checked last.</p> <p>Chapter 3, Section 202.15, package integrity, of the 2022 FDA Food Code documents:</p> <p>Food packages shall be in good condition and protect the integrity of the contents so that the Food is not exposed to adulteration or potential contaminants.</p> <p>The facility policy titled Safe Food Storage Policy updated 5/19 instructed the staff to make sure all goods are dated with received dates, store all food in the original containers, and label, date and properly cover all food items upon opening of package.</p> <p>The facility policy titled Sanitizing Solution Policy dated 9/20 instructed the staff to proper sanitizer concentration (buckets, spray bottles, sinks, and/or disposable wipes) should be ensured by checking the solution periodically with an appropriate chemical test strip-at minimum of once daily. Sanitizer solution log will be completed daily and stored in each foodservice area used throughout building.</p> <p>47079</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. On 8/05/24 at 12:02 PM, Staff D, cook, scratched the left side of his head, picked up some meal tickets, placed them down on another part of the service table, then placed his left thumb inside the soup bowl as he picked it up. He placed soup inside the bowl and it was served to a resident.</p> <p>At 12:04 PM, Staff D put his left thumb inside small bowl used to serve pears for another resident. No hand hygiene or removal of the gloves occurred.</p> <p>The facility did not have a policy for food service sanitation.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47079</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, staff interviews, record reviews, and policy review, the facility failed to implement the Infection Prevention and Control Program (IPCP) by staff not discarding Personal Protective Equipment (PPE) immediately after use. The facility reported a census of 35 residents.</p> <p>Findings include:</p> <p>On 8/07/24 at 9:30 AM, two (2) Person Protective Equipment (PPE) gowns were observed hanging on a hook rack in a resident's room with Enhanced Barrier Precautions in place.</p> <p>At 9:31 AM, Staff A, Certified Nurse Aide (CNA) stated the PPE gowns were required due to the resident's sacral wound. She stated the gowns were hung on the hook rack so they would be closer to the door. She stated when staff were finished using the PPE gowns, they hung them back up or got new one. She stated there was no way to know who used which gown but identified the gown on the right hook was the one she used.</p> <p>At 9:41 AM, Staff B, Health Information Manager (Medical Records) provided the PPE gown product number which indicated the manufacturer identified the PPE gowns as single-use gowns.</p> <p>At 1:22 PM, Staff C, Registered Nurse (RN), was observed in the resident's room wearing a PPE gown. He stated he got it from the hook rack on the wall beside another hung PPE gown. He stated the gown he wore was already hanging on the right hook.</p> <p>At 4:10 PM, the Infection Preventionist stated the facility was reusing PPE gowns to conserve resources. She also stated staff should not use other staff's used PPE.</p> <p>A document titled Application of Gown Technique dated 2020 directed staff to use a fresh gown each time one is needed.</p>		