STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165796	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anthony Nursing Home	406 East Anthony Street Carroll, IA 51401

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40905 Based on resident record review, staff interviews, observation and facility policy review the facility failed to verify the resident's advanced directive choice documented accurately for 1 (Resident #58) of 24 residents reviewed. The facility reported a census of 76 residents. Findings include: The Resident Dashboard for Resident #58, dated [DATE], documented the resident was admitted to the facility on [DATE] and a current Code Status, Advanced Directive of Do Not Attempt Resuscitation (DNR). Resident #58's Iowa Physician Orders for Scope of Treatment (IPOST), signed by the physician [DATE], documented Cardio Pulmonary Resuscitation (CPR). Resident #58's Iowa Physician Orders for Scope of Treatment (IPOST), signed by the physician [DATE], documented DNR. Resident #58's Order Summary Report dated [DATE], documented a physician's order for DNR with order date [DATE]. Interview on [DATE] at 1:25 PM, Staff G, Registered Nurse stated all full code residents are listed on a sheet at the nurse's station, charts are purple, have star on the nametag at resident's room doorway, and have a red band on their walker or wheelchair and in an emergency situation that is the order she would look for the code status usually, depending on where the resident is. Observation on [DATE] at 3:30 PM, Resident #58 did not have a star on the name tag at room doorway, chart was green, and no red band observed on bed or wheelchair. Resident #58 was not on the Full Code list in the nurse's station. Facility policy, Advanced Directives last revised ,d+[DATE], documented changes to the resident choices for advanced directives will be documented, included in the resident plan of care, Iowa specific documents will be updated as necessary, physician orders will be obtained to reflect new choices as applicable and all items will be communicated to staff providing resident care. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 1:49 PM, the Director of Nursing confirmed the physician's order and IPOST did not match and her expectation to for the records to be accurate and match.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40905 Based on resident record review, staff interview, and facility policy review the facility failed to develop and implement a comprehensive person-centered care plan to include a resident's diagnoses and treatment for urinary tract infection two times since admission and history of within 30 days of admission for 1 resident (Resident #16) of 18 residents reviewed for care plans. The facility reported a census of 76 residents. Findings include: The Minimum Data Set (MDS) for Resident #16, dated 10/31/24, included diagnosis Non-Alzheimer's Dementia and Urinary Tract Infection (UTI) (in the last 30 days). The MDS documented the resident was frequently incontinent of urine. Resident #16's Medication Administration Record (MAR) for 11/24 - 11/30/24 documented a physician's order started 11/27/24 for Macrobid (urinary anti-infective medication) two times a day for a UTI. Resident #16's Order Summary Report dated 1/22/25, documented a physician's order dated 1/14/25 for Cefurixine (antibiotic medication) two times a day for UTI for 10 days. Resident #16's Care Plan lacked inclusion of the UTI's, treatment, and interventions to prevent/monitor. Facility policy Comprehensive Care Plan Development last revised 10/2023, revealed the Care Plan will include measurable objectives and time frames to meet the resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. Interview on 1/23/25 at 9:02 AM, Staff H, MDS Coordinator confirmed the UTI's were not included the resident's care plan and expectation for the UTI's to be included in the care plan.

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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 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** 41785 Based on observation, interview and clinical record review, the facility failed to ensure an accurate accounting of Scheduled 2 (II) (high potential for abuse) controlled medications for 1 of 3 residents reviewed. On 1/3/25, staff reported that Resident #44 was missing a dose of Ativan. The facility reported a census of 76 residents. Findings include: According to the Minimum Data Set, dated dated dated [DATE], Resident #44 was rarely understood so he was unable to complete Brief Interview for Mental Status assessment. Resident #44 required substantial assistance with toileting, showering and dressing, and supervision only with chair to bed transfers and walking. The resident had disorganized thinking, hallucinations, delusions, and daily physical symptoms directed toward others such as hitting, grabbing and pushing. The Care Plan for Resident #44 showed that the resident had episodes of behaviors such as combativeness, name calling and occasional refusal of medication/care resist cares. Staff were directed to administer medication as ordered and to monitor/document for side effects and effectiveness. A Nursing Note dated 1/3/25 at 11:40 AM, showed that on the morning of 1/3/25, Staff B Licensed Practical Nurse (LPN), discovered that the number of Ativan for Resident #44 did not match the number of Ativan that had been used. The Orders tab in the electronic chart showed that Resident #44 had an order dated 5/24/24 at 4:13 PM, for lorazepam (Ativan) topical gel, 0.5 milligrams/0.25 milliliter. Apply to wrist topically every 4 hours as needed for anxiety and behaviors, And, apply to wrist topically three times a day for anxiety and behaviors; mid-morning, midafternoon and at bedtime. A Pharmacy Delivery Note, signed by Staff F, Registered Nurse (RN), showed that on 12/31/25, 45 syringes of topical Ativan had been delivered to the facility. The Resident Controlled Substance Record for Resident #44 showed that with the addition of the 45 syringes, on 12/31/24 at 6:30 PM, there were 50 total syringes. The medication was used 7 times from the time of delivery until the night of 1/2/25. Upon count on 1/3/25 at 7:30 AM, there were 42 syringes remaining. On 1/21/25 at 10:45 AM, Staff D, LPN, said that on the morning of 1/2/25, she counted the narcotics with the overnight nurse and everything had been verified. She said that looked at the Ativan syringes for Resident #44, and counted the bundles and compared to the narc sheets with no concerns. She said that when she counted again at 2:00 PM with Staff C there were no discrepancies and they had counted each syringe in the bundles. They were not in a hurry and did not get disrupted during the count. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 10:01 AM, Staff C, LPN said that when she came into work at the 2:00 PM on 1/2/25, the outgoing nurse, Staff D was in a rush and told her she didn't need to count all of the syringes. She said that she made the mistake of believing that there were 10 in each bundle and didn't verify. Staff C said that Staff D had given two doses on the day shift, but had only documented that one had been given. She said that she didn't really know what the expectation was for counting of scheduled medications. In an observation on 1/22/25 at 7:35 AM, it was discovered that Staff D had signed the Nurses; Count of Narcotics and Drugs spreadsheet for the ongoing shift at 6:00 AM and also for the outgoing nurse at 2:00 PM. On 1/22/25 at 10:17 AM, Staff B said that when she worked on the morning of 1/3/25 and counted the narcotics with the overnight nurse, (Staff A), Staff A, LPN told her that there had been one Ativan missing from one of the bundles when she counted with the outgoing nurse at 10:00 PM the night before. Staff B acknowledged that the syringes were delivered in bundles of ten, with a rubber band holding the bundle together. She said that she would always count to make sure there were 10 in each of the bundles. On 1/3/25, one of the bundles had just 9 syringes. On 1/22/25 at 10:55 AM, Staff A, LPN said that she worked the overnight shift on 1/2/25 and before she started her shift at 10:00 PM, she counted the Schedule II medications with Staff C. At that time, the number of Ativan syringes for Resident #44, did not correspond with the documentation. She looked around in the drawers and in the medication room for the missing syringe. When she did not find it, she went on with her shift, hoping that it would show up somewhere throughout the night. Staff A acknowledged that in the past, there were times that the nurses would get in a hurry with the counting between shifts, and they wouldn't always look at the bundles to confirm that there were 10 in each bundle. On 1/22/25 at 2:27 PM, Staff E, LPN said that she worked full time at the facility and was aware of the expectation to count all of the Schedule II medications at shift change. She acknowledged that there were times when the nurses would get in a hurry and not count all of the individual syringes in the bundles. On 1/22/25 at 2:13 PM, when asked why she had signed on the line for the 2:00 PM outgoing shift earlier that morning, Staff D she that she was taught to sign both lines right away. She acknowledged that the purpose of the signature would be to verify that she had counted the Schedule II drugs with another nurse. On 1/23/25 at 10:15 AM, The Director of Nursing (DON) said that the nurses were expected to sign the shift change sheet at the time that they count with the other nurse. She said that the agency staff were taught about processes and expectation at the time of orientation. According to the Orientation Checklist For Nurses, Staff C had initialed the Trainee and Trainer columns. The checklist lacked reference to an orientation on the counting and verification of Schedule II medications. According to the Facility Policy titled: Narcotic Medication Management, last reviewed on 2/2024, Narcotic counts would be conducted at shift change by the oncoming nurse and outgoing nurse. Any discrepancies would be reported immediately to the supervisor.

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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. 48886 Based on observation, staff interviews and policy review, the facility failed to ensure open items were dated, covered and labeled. The facility further failed to ensure staff used proper hand hygiene practices during lunch service while serving food. The facility reported a census of 76 residents. Findings include: 1. Observation 1/21/25 at 10:00 AM in the main kitchen with Staff I, Food and Service Director, present revealed the following: a. Two open undated bags of pasta b. Open undated bag of graham cracker crumbs During an interview 1/21/25 at 10:20 AM, Staff I stated an expectation the food is dated, labeled and sealed after it is opened. Staff I stated an intention to label and date these food items and return them to the pantry. Review of the facility Food Storage Guidelines policy, with a revision date of 12/24, documented food not served in the service of a meal will be handled safely to prevent contamination or spoilage. Unused foods are identified, labeled and dated. 2. During an observation 1/21/25, beginning at 11:30 AM, Staff J, kitchen staff, served residents lunch, plated the food without sanitizing hands in between. Observed Staff J touch the tip of a straw while taking it out of a wrapper and place it in a resident's cup, stirring the chocolate milk with the tip of the straw. Staff J opened cartons of milk for two residents, touching the inner carton where a resident drinks from. Staff J then served two residents, getting the flood plated from the steam table without sanitizing hands in between; touched the tray, dishware, serving utensils and plates, bowls. Staff J then went into the kitchen, touching handle to kitchen door, came back out of the kitchen and did not sanitize hands, began plating food for a resident. Staff J touched a hamburger bun with bare hands while cutting it in half with a knife. Staff J then served the resident, did not sanitize hands. During an observation 1/22/25, beginning at 11:15 AM, Staff K, kitchen staff, did not sanitize her hands in between serving residents. Staff K would plate the food and drinks and silverware, touching surfaces, then deliver the food to residents, touching the table, and at times assisting residents with taking the lid off of ice cream or using the resident's spoon to stir or their knife and fork to cut food. Staff K opened resident's milk cartons, touching the interior of the carton. Staff K served several residents without sanitizing her hands in between residents, touching several surfaces and plating food for residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 1/22/25 at 1:01 PM, the Director of Nursing (DON) stated an expectation staff sanitize their hands in between serving residents, there is a hand sanitizer dispenser next to the tray cart, they are expected to put the tray used to serve a resident on the tray cart, and then sanitize their hands before getting a clean tray and serving another resident. During an interview 1/22/25 at 1:20 PM, Staff I stated an expectation staff sanitize their hands in between serving residents. Review of the facility Infection Prevention and Control/Employee Health and Hygiene/Hand Washing in Food and Nutrition policy, with a revision date of 12/24, documented food employees shall keep their hands and exposed portions of their arms clean to prevent foodborne illnesses and the spread of communicable diseases.