STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165798	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmar Village	8900 C Avenue NE Marion, IA 52302

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46873 Based on observations, resident interview, staff interview, review of Resident Council minutes, and facility policy review, the facility failed to treat each resident with dignity and respect. The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set of Resident #3 dated 12/3/24 identified a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. The Care Plan of Resident #3 identified she was receiving occupational and physical therapy. The Care Plan documented that the resident required the assistance of 1 staff member for ambulation, dated 1/16/25, and assistance of 1 staff member for bed mobility, dated 1/16/25. The Care Plan documented the resident required the assistance of 1 staff member for transfers, dated 1/17/25. On 1/21/25 at 1:30 pm, Staff I, Occupational Therapist, was observed walking into the nursing station after leaving the room of Resident #3. She was heard directing staff J, Certified Nurse Aide not to give assistance to Resident #3. She stated the resident will ask for assistance to put chapstick on and directed Staff J not to do it. She stated the resident is independent and she had deemed her independent the week prior. She stated she needs assistance to go to the dining room but is independent in her room and if she asks the staff to put chapstick on her they are to tell her that she is independent. On 1/21/25 at 1:33 pm, Staff J stated that Resident #3 asks for help for most everything. She stated staff needs to encourage her to do things for herself, or at least try. But if she is unable to do things, then staff does assist her. On 1/21/25 at 1:36 pm, Staff I was back in Resident #3's room and was heard telling her that she is independent and needed to complete tasks on her own. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165798	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/21/25 at 1:39 pm, Staff I stated it is ok for staff to remove the lid of the chapstick for Resident #3. She stated the resident can do things for herself but she continues to ask for staff assistance. She stated the resident is back to her baseline following a fall earlier in the month and is getting ready to discharge from therapy. She stated it is ok for the resident to sometimes ask for help, but that she needs to be independent and therapy does not want to discharge her when she continues to ask for help. She stated for trivial things she needs to understand she can do things on her own. Staff I left the interview to take a phone call and did not return. On 1/21/25 at 1:39 pm, Resident #3 stated there is one CNA, who she identified as Staff K who often answers her call light when she rings for restroom assistance. She stated Staff K will turn off her call light and tell her that she doesn't think the resident really needs to go to the bathroom and will leave the room without assisting her. She stated she had reported this to facility management. She stated when she needs assistance for the restroom and then staff tells her she doesn't really need to go to the bathroom, she feels this is ridiculous. Resident #3 then added that Staff I, Occupational Therapist had told her that day that she was independent and to do things for herself. She stated she had had three bowel movements that day and had been incontinent. She stated she asked Staff I for assistance to remove her soiled incontinent brief and Staff I told her she needed to do it herself. She stated she tried and was unable. She said she had to ask Staff I for assistance three times before she helped her. She said that Staff I told her You are independent and you can rip it off of yourself. Resident #3 stated she felt very frustrated, as she was wearing a brief soiled from fecal incontinence and wanted help to get clean. Resident #3 also added to the conversation that she often misses her baths. She stated recently an employee stated she was going to give her a bath but there were not enough towels. She left to go find towels and never returned and the resident did not get her bath. 2. The Minimum Data Set (MDS) of Resident #4 dated 1/2/25 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS documented the resident required substantial/maximal assistance for showering/bathing. The Care Plan of Resident #4, documented the resident required assistance of 1 staff member to bathe and desired to bathe once a week on Saturdays, dated 12/7/23. On 1/21/25, Resident #4 stated in a recent resident council meeting, getting showers done was one of the topics brought up by the residents in the meeting. She stated her preference is to shower only on Saturdays, and desires her shower to be done by 6:45 am. She stated staff often want to wait until 9:00 or 10:00 am, after she is already dressed. She said she doesn't want to get dressed, then have to get undressed to shower and get dressed a second time. She said getting her shower on the day and time she requests it is the only big request that she makes and she feels staff should provide this. She added that staff regularly tells her they are too busy, they have other residents who need to get to breakfast too. She stated they need to realize she is one of those people too and she needs their help. Resident #4 continued, stating that it shouldn't be hard, only once a week, but it is always that they don't have time, and staff is always rushed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/22/25 at 7:32 am, the Clinical Coordinator stated he was not aware of any residents having concerns with dignity or respect. When asked specifically about Staff K, he stated she is from another country and at times she needed to be reminded to lower her volume when she communicates. He stated there are cultural differences and she needs to slow down, and speak quieter as it can be perceived as aggressive when it's not intended to be. He stated he had never received any report of her with issues with call lights. In regards to Staff I, he stated her authority as an Occupational Therapist does not include directing the nursing staff. He said it was not her place to instruct the staff to not provide assistance and the nursing staff knows that. He stated this had been addressed with Staff I. He added that if a resident is independent they can still ask for any help they need and staff will be more than happy to help them. On 1/22/25 at 2:08 pm, Staff F, CNA requested to speak to the State Surveyor regarding some staffing concerns in the facility. She stated there are some other CNAs who sit and eat meals when they are not officially on break and don't answer call lights during this time. She stated on a recent shift Resident #5's call light was on for over 45 minutes while the staff member assigned to the room sat in the dining room eating. She stated staff often leave linens soiled with feces in resident rooms and don't take out trash. Resident Council Meeting Notes from 11/11/24 included the following concerns brought up by residents: - Staff not introducing themselves when entering residents' rooms - Staff speaking to each other and not engaging the residents when working with them - Staff not taking residents to the bathroom when needed. Staff will tell residents You just went and make the residents wait - Residents raising their hands for help when in the dining room and staff just walking past them without helping. Resident Council Meeting Notes from 12/9/24 included the following concerns brought up by residents: - Staff who are vision impaired not receiving guidance where to find their food at meal time - Residents being told the person who was to give showers didn't come to work so they can't get a shower - Staff answering a call light, turning it off and telling the resident they will return but then it takes 45 minutes before they come back - Residents want staff to treat them with respect and dignity - When staff say You're lying that is unacceptable - Residents do not want to receive insulin injections at the dining table (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Residents do not want to be asked about their pain level at the dining table - Private things should not be discussed in front of others Resident Council Meeting Notes from 1/13/25 included the following concerns brought up by residents: - If residents are given a time for a shower, then is when the shower should be given - When residents put call lights on, staff replied Don't put your call light on so much, I'm busy taking a nap - Residents say they were told by staff when they ask to go to the bathroom she won't come down because this person has already gone enough times - Staff on phone during lunch when they should be helping the residents - Staff sit during meals and don't help residents - Staff leave trash in the room with soiled incontinence briefs The facility policy Resident Rights Policy, Modified November 2022 documented the following: The resident service department or designee informs the resident of Resident's Rights at the time of admission and at periodic intervals throughout the resident's care period. The facility uses person centered care to give personalized attention to the well-being of each resident while enhancing their independence and dignity. Person centered care includes resident's exercising their freedom to decide what their best day looks like. Staff will collaborate with residents on a routine basis to discover what their most pleasing day looks like.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46873 Based on clinical record review, review of resident council notes, resident interview, and staff interview, the facility failed to provide consistent bathing for 2 of 5 residents reviewed for bathing (Resident #4 and Resident #7) . The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set (MDS) of Resident #4 dated 1/2/25 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS documented the resident required substantial/maximal assistance for showering/bathing. The Care Plan of Resident #4, documented the resident required assistance of 1 staff member to bathe and desired to bathe once a week on Saturdays, dated 12/7/23. On 1/21/25, Resident #4 stated in a recent resident council meeting, getting showers done was one of the topics brought up by the residents in the meeting. She stated her preference is to shower only on Saturdays, and desires her shower to be done by 6:45 am. She stated staff often want to wait until 9:00 or 10:00 am, after she is already dressed. She said she doesn't want to get dressed, then have to get undressed to shower and get dressed a second time. She said getting her shower on the day and time she requests it is the only big request that she makes and she feels staff should provide this. She added that staff regularly tell her they are too busy, they have other residents who need to get to breakfast too. She stated they need to realize she is one of those people too and she needs their help. Resident #4 continued, stating that it shouldn't be hard, only once a week, but it is always that they don't have time, and staff are always rushed. The last 30 days of bathing task record for Resident #4 documented she received bathing on 12/28/24, 1/4/25 and 1/11/25. All were charted between 11:00 am and 2:00 pm. On 1/18/25 at 2:00 pm, bathing was charted as refused. 2. The MDS of Resident #7, dated 10/23/24 documented the resident to be fully dependent on staff for bathing. The last 30 days of bathing task record for Resident #7 documented he received bathing on 12/28/24, 1/1/25, 1/15/25 and 1/18/25. On six dates between 1/1/25 and 1/15/25, his bathing was documented as not applicable. On 1/22/25 at 12:51 pm, the Clinical Administrator stated she was unaware of Resident #7 not receiving baths. She stated she would look at his records and discuss it with floor staff. She stated at that time, all charting for baths is to be done through the Electronic Health Records of the residents. She stated she is working on implementing shower books to start holding staff accountable for completing baths based on complaints from residents during Resident Council Meetings. Review of minutes from the last 3 months of resident council meetings revealed receiving baths as scheduled was discussed at all meetings.

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, employee record review, staff and resident interviews, and facility policy review, the facility failed to provide adequate supervision for residents who occupied a 14 room shift assignment. This resulted in harm to Resident #3 due to her walker being left out of reach when she was put to bed, leading to a fall with injury. Staff failed to perform safety rounds and the resident was not found by staff for a significant amount of time after the fall. Additionally, other residents of the shift assignment were left without call lights in reach and others with call lights going unanswered. The facility reported a census of 50 residents. Findings include: The Minimum Data Set of Resident #3 dated 12/3/24 identified a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. The MDS indicated the resident had not had any falls since the prior assessment. The Care Plan documented that on 9/6/24 the resident was deemed to be independent in her room with her walker. The General Note dated 1/5/25 at 6:20 am, authored by Staff D, Licensed Practical Nurse (LPN) noted the resident was found lying on the floor with blood all over the carpet, resident lying on her left side. The Note documented the resident's walker was tipped on its side by the dresser and the call light was secured to the side rail of the bed. The resident was bleeding from a wound to her head. Emergency services were called and the resident was transferred to the hospital. On 1/21/25 at 1:21 pm, the Administrator stated the staff on duty for the night shift of 1/4/25 was Staff D, LPN, and Staff A, Certified Nurse Aide (CNA). On 1/21/25 at 3:20 pm, Resident #3 stated that on the night she fell , the person who put her to bed put her walker out of reach. She stated when she went to get up, she tried to reach the walker but it was by her dresser and when she attempted to walk to obtain it, she fell and hit her head. She stated it was dark in the room and she could not see her clock. She said she remembered around 1:00 in the morning, staff had been in the room bringing fresh ice water. She thought it might have been around 2:00 in the morning when she fell . She said her normal routine is to use the toilet every two hours or so. She said she stayed on the floor until she heard footsteps in the hallway and then she called out for help. She stated Staff B, CNA was the first person who found her after she called for help. She thought it was around 6:00 in the morning when she was found. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	On 1/21/25 at 4:36 pm, Staff B, CNA stated he had arrived for work at 6:00 am on 1/5/25. He was not assigned to Resident #3's room. He said he found Staff A, CNA and received a report on his assigned residents. He then began his morning routine and after assisting another resident, he was transporting soiled linens down the hall when he heard Resident #3 calling for help. He stated he did not immediately know which room the call was coming from and he entered a couple of other rooms trying to locate who was calling out. When he entered the room of Resident #3, he noticed her lying on the floor with blood, and could tell she had been moving around due to the trail of blood on the carpet. He checked on her, found her to be alert, and immediately went to find the nurse for assistance. Staff B stated it was around 6:20 am when he found the resident on the floor. He said that the resident told him she thought she had been on the floor since approximately 4:00 am. He stated he did not see Staff A at any time after he received report from her and he did not know when she had left the building. On 1/22/25 at 7:32 am, the Household Coordinator stated Staff A was investigated following Resident #3's fall. He stated she had been terminated due to conduct. He said in the investigation of the fall, it was reported to him that the resident believed she had fallen in the time frame of 4:00 am. He said the night shift is to make rounds every two hours, and the shift begins at 10:00 pm. He said he would expect first rounds to be around 11:00 pm and then every 2 hours but there is flexibility on that with how long shift exchange takes. He stated the off going and on coming shifts are to do walking rounds together in each room. On 1/22/25 at 9:36 am, Staff C, CNA stated she was assigned to Resident #3 on the morning shift of 1/5/25. She stated she and Staff A began to do walking rounds with Resident #5, in room [ROOM NUMBER]. Resident #3 was in room [ROOM NUMBER]. She stated Staff A told her she had not checked on Resident #5 the entire night because she had not rung her call light. She said she immediately told Staff A all residents had to be rounded on, not only when call lights were rang and instructed her to go and check on Resident #5. She said she then turned back down the hall to wait for Staff A to finish so they could continue report but then started hearing someone calling for help. She said she entered the room of Resident #3 shortly after Staff B had entered. She said when they found Resident #3, Staff A had already left. She did not know when she left and never obtained a report from her on any other residents. Staff C stated that even for residents who are independent in their rooms, staff were still supposed to check on them, verify they have their call light and anything they need. She stated Resident #3 often still calls for help for going to the restroom or assistance with her shoes and other things. On 1/22/25 at 10:00 am, an attempt to reach Staff A by phone was made. The phone number had been disconnected. On 1/22/25 at 10:55 am, Staff D, LPN stated on 1/5/25 around 4:00 or 4:30 am, she had found Staff A sleeping in the lounge. She said for the last hour or so she had been on the other part of the hall, rounding with the other CNA on duty and assisting residents on that side of the hall. She said when she returned to the nurses station, she saw the call light monitor and noted there was a call light that had been ringing for over an hour. She said she went looking for Staff A and found her sleeping in the lounge area of the second floor. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Staff D explained she had been the staff member who had assisted Resident #3 to bed the night before. She described she had administered the resident's bedtime insulin and eye drops and helped her to bed. She was unable to recall where the resident's walker had been left when she assisted her to bed. She said at night the CNAs normally do rounds at 1:00 am and 4:00 am. She said prior to 1:00 am, Staff A had told her she was going to go do rounds and Staff D told her to get her if she needed assistance but Staff A never asked for assistance that night. She said when day shift arrived, she instructed them to do walking rounds with Staff A and they stated they would but she was unaware of when Staff A left. Staff D recalled that prior to Resident #3 being found on the floor that morning, she was down the hall with the medication cart administering morning medications. She said she was coming down the hall and the CNAs came and got her explaining they had heard someone calling for help. She stated when she entered the room, the resident was lying on her left side, looking across the room. She described there being blood everywhere from the dresser to where the resident was lying by the bed. She stated she was not sure what the resident had hit her head on and could not recall seeing the walker. She stated she instructed the CNA to apply pressure to the wound, she went to get a second nurse and to call for an ambulance. Staff D commented when she had worked with Staff A on prior shifts, she had never caught her sleeping before. However, she said day shift staff often reported that several residents would be heavily wet with incontinence following shifts that Staff A was on duty on the night shift. On 1/22/25 at 12:39 pm, the Clinical Administrator stated she had spoken to Staff D regarding Resident #3's fall. She stated the conversation was via text and Staff D had notified her about finding Staff A sleeping in the lounge. She said Staff A was immediately suspended pending the outcome of the investigation. She said after reviewing the call light log, their main concern outside of Resident #3's fall was one call light that was on for over an hour prior to Staff D finding and waking up Staff A. The Clinical Administrator also said that Staff D had told her that she didn't think Staff A had ever rounded at all during the entire shift because two of the residents on the hallway required a 2 person assistance for rounds and Staff A never asked for help the entire shift. The Clinical Administrator stated the night shift is to round every 2 hours, which included checking all residents, changing residents who are incontinent, and repositioning those who need assistance to reposition. She stated that while Resident #3 was independent in her room, she would still expect her to be checked on for safety every 2 hours. Review of Staff A's employee file revealed a Notice of Termination. The Notice stated During the NOC (night) shift on 1/4/2025, the charge nurse reported that you were found sleeping in the lounge on the second floor. The charge nurse had to wake you to answer call lights. The Note further documented during a phone call with Human Resources, Staff A stated she was not originally planning to work that night due to low census but ended up picking up the shift for a coworker who asked her to work for her. Staff A reported she was not feeling well and she had an off day. The Notice also documented, after further investigation, that various residents assigned to Staff A were found to not have their call lights in reach, and were not checked and changed, resulting in residents being left in soiled clothing. The Notice documented Resident #3 being found on the floor suffering a head wound by the oncoming shift, and that the oncoming shift reported walking rounds were not completed at shift exchange. Staff A was notified on 1/9/25 via telephone that her employment was terminated. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	The Device Activity Report (Call Light Report) for the overnight shift on 1/4/25 for Staff A's room assignment revealed room [ROOM NUMBER] call light was triggered at 3:43 am and was answered at 4:44 am. The report revealed three other call lights during the shift were answered greater than 15 minutes after being rang. The Resident Assistant (CNA) Position Description and Performance Review directed the Resident Assistant is responsible for the provision of high-quality care and services to residents to support the choices of the residents, while maintaining consistency with regulations and established best practices. The Supervisor/Manager Coaching Note revealed Staff A had received coaching on 11/3/24 on the importance of rounding on all assigned patients, in addition to removing trash and soiled linens from the rooms. The Role Orientation Checklist of Staff A documented Staff A had received training on 11/12/2023 of maintaining resident room order including call lights and personal items to be kept in reach. The facility policy Call Light Policy, modified November 2022 documented the following: Point 1: All facility personnel must be aware of call lights at all times. Point 2: Answer all call lights promptly, whether or not you are assigned to the resident. Point 4: Answer all call lights in a prompt, calm, courteous manner, turn off the call light as soon as possible.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, staff interview, and facility policy review, the facility failed to retain complete and accurate medical records for Resident #6. The facility also failed to accurately transcribe orders from a medical provider for Resident #7. The facility reported a census of 50 residents. Findings include: 1. The Minimum Data Set (MDS) of Resident #6, dated 12/5/14 identified a diagnosis of pneumonitis due to inhalation of food. The MDS documented the resident received anti anxiety medication during the 7-day assessment reference period. The Care Plan of Resident #6 identified a Focus Area of use of anticonvulsant, antihistamine, and benzodiazepine medications dated 12/9/24. The Medication Administration Record (MAR) for December of 2024 documented Resident #6 had an order for Lorazepam (also known as Ativan, a benzodiazepine/anti anxiety medication), 0.5 mg, every four hours as needed, start date of 12/2/24, discontinued 12/16/24. The MAR failed to document the resident had been administered a single dose of the medication. On 1/22/25 at 12:39 pm, the Clinical Administrator stated she would look for his records but she recalled the order was discontinued because he had never utilized the medication. She stated the narcotic sheets do not get uploaded to the resident's electronic health record but are stored in a binder in the office of Staff G, scheduler/medical records. On 1/22/25 at 1:15 pm, Staff G, scheduler/medical records, provided one Controlled Drug Receipt/Record/Disposition form for Resident #6 for Lorazepam, 0.5 mg tablets. The form identified the pharmacy had dispensed 30 tablets of medication on 11/29/24. The facility was only able to provide page 2 of the form, start date of 12/21/24 which documented the resident had 28 of 30 tablets remaining. The form documented on 12/30/24 two staff members destroyed the remaining 28 tablets per policy due to the resident not using the medication and the order being discontinued. On 1/22/25 at 2:46 pm, the Administrator stated in an email the facility was unable to locate the missing Page 1 of the the Controlled Drug Receipt/Record/Disposition form for Resident #6. She verified the 28 doses remaining were destroyed using drug buster (a liquid used to destroy unneeded medications). She also stated the pharmacy verified with her the medications were delivered to the facility on [DATE]. 2. The MDS of Resident #7, dated 10/23/24, documented diagnoses that included heart failure, Parkinson's disease, and depression. The Care Plan, revision date of 7/29/24 documented a self performance deficit of Activities of Assisted Living related to weakness, impaired mobility, Parkinson's Disease, Congestive Heart Failure, and cognitive impairments. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165798	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmar Village	8900 C Avenue NE Marion, IA 52302

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Fax cover sheet dated 12/12/24 documented the facility notified the Advanced Registered Nurse Practitioner (ARNP) the resident's Carbidopa-Levodopa (Parkinson's Disease medication) was scheduled to end on 12/12/24 and requested orders regarding an additional medication, Entacapone. The ARNP responded on this sheet the taper was ending but the dosage was to remain the same and to see orders. The sheet was time stamped 12/12/24 at 1:02 pm. On the Note To Attending Provider sheet, time stamped 12/12/24 at 1:03 pm, the ARNP noted to not discontinue the Carbidopa-Levodopa and to remain at the current dose. She gave additional orders for the second medication, Entacapone, on the lower portion of the form. The Medication Administration Record (MAR) for December of 2024 documented that order for the Resident's Carbidopa-Levodopa ended on 12/12/24 and was not given the remainder of the month. The MAR also reflected that the new order for the Entacapone was started on 12/12/24, the date of the order. The Physician's Order Note, authored by Staff E, Registered Nurse (RN) noted an order had been received by the ARNP per response from pharmacy to taper the Entacapone to 100 mg four times a day for 14 days and then discontinue. The ARNP which was named in this note was not the same ARNP who actually wrote the order. On 1/16/25 at 12:38 pm, a family member of resident #7 stated the Resident had been suffering a lot of hallucinations which was thought to be a side effect of his Parkinson's medication. It was recommended to taper the medications to a lower dose to help the side effects. The family member stated during the time he was without the medication, the hallucinations did greatly subside but symptoms of his Parkinson's also worsened. She stated his tremors returned during this time period, but stopped again once the medication was restarted. On 1/22/25 at 12:26 pm, the Clinical Administrator stated she had received an email from the pharmacy stating Resident #7 was tapering off of his Carbidopa-Levodopa and therefore his Entacapone also needed to be discontinued. She stated that it was sent to the ARNP and the facility received clarification of the Entacapone. She stated she had not seen the note from the ARNP stating to continue the Carbidopa-Levodopa until a copy of it was provided to her from the family of Resident #7. The Clinical Administrator was unable to provide a copy of any other order being received regarding the Entacapone. The Clinical Administrator also stated that Staff E wrote the Progress Note regarding receiving orders from an alternate ARNP. She verified the named ARNP in the note was not an attending or prescribing provider for Resident #7 and would not give any orders regarding Resident #7. The Clinical Administrator stated shortly after this error was discovered, Staff E started calling off from work and had not since returned. She stated she had prior concerns regarding Staff E's job performance and had intended to have her start some job shadowing to re-educate on proper procedures. She stated she did not know where Staff E received the order for Entacapone as the facility had no copy of the order on file anywhere. She also stated when the resident's family was made aware Resident #7 was not receiving the medication, they came to the charge nurse with their copy of the order from the Memory Clinic. The charge nurse corrected the order at that time, on 1/6/25. She stated the family also brought the error to her attention and she verified the order was correct at that time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165798	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmar Village	8900 C Avenue NE Marion, IA 52302

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Clinical Administrator stated the normal process when an order is received via fax is to note the order (sign and date it), then after placing the order in the computer place it in a folder for double noting (another nurse checking the order was correctly placed in the computer). After the order is double noted, it goes into a box to get scanned into the resident's chart. On 1/22/24 at 2:40 pm, Staff E, RN stated she recalled seeing an order for Resident #7's Entacapone to be decreased. She stated it was too long ago and she did not remember details but knew there had been some sort of misunderstanding. She stated she read the order and made the change to the Entacapone but didn't recall anything else specific. She stated double noting of orders was not the procedure at the time of this order. She stated she would have put the order in the resident's electronic health record and faxed it to the pharmacy and then it would go in a box for management to double check it. She said after management looked everything over then it would get scanned into the resident's chart. The facility policy Record Retention Policy, dated 6/8/2018 documented the following: All records of [name of facility] shall be retained in accordance with federal and state regulations and laws. All other documents addressed in this Policy shall comply with the retention periods set forth below, at minimum. In the Appendix to Record Retention Policy, dated 12/12/2022, it identified Narcotic Signature Logs are to be retained for [AGE] years in the State of Iowa.