STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165438	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stacyville Community Nursing Home	413 South Broad Street , Stacyville, Iowa, 50476

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 ✓	INITIAL COMMENTS Correction date: 4/23/26_____ The following deficiencies resulted from investigation of facility reported incidents #2658945-I and #2745420-I conducted April 20, 2026 to April 22, 2026. Facility reported incidents #2658945-I and #2745420-I were substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that a deficiency exists or that one has been cited correctly. This plan of correction is submitted to meet established requirements by the state and federal law.	
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of Mary Lt 5/6/2026	F0755	To remain in compliance with F0755, Resident #2's controlled substances were reconciled with no discrepancies. Staff involved were immediately re-educated on proper controlled substance counting, including verifying the medication, resident, and count against the bubble pack. A 100% audit of all controlled substances was completed. No additional issues noted; any discrepancies would be addressed per policy. Policy reinforced on 4/20/26 requiring two staff to complete shift counts with nurse present with direct comparison of bubble pack to count sheet. All licensed nurses and CMAs educated. Consultant pharmacist available for oversight. DON/designee will randomly audit controlled substance counts 3 times weekly x4 weeks, then monthly x3 months. Results reviewed in QAPI.	

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F0755 SS = D	Continued from page 1 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure one of 3 residents (Resident #2) remained free from a medication error, failed to document the error in the clinical record, and failed to follow professional standards for reconciling controlled drugs (medications with a high potential for abuse). The facility reported a census of 23 residents. Findings include: Resident #2's quarterly Minimum Data Set (MDS) assessment dated 3/9/26 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of Parkinson's disease (brain disorder), depression, and sleep apnea (breathing stops during sleep). The MDS documented he received an antianxiety medication (medication used to treat anxiety) during the 7-day lookback period. On 4/20/26 at 1:58 PM, observed Staff C, Certified Medication Aide (CMA), and Staff D, CMA, performing the controlled drug count for the shift change. Staff C looked at the bubble packs for the controlled drugs and Staff D read the count off the controlled drug sheets in the binder. Staff C didn't compare the bubble pack to the sheet to ensure it was the right resident, medication, and correct count. Staff E, Licensed Practical Nurse (LPN), stood to the side of the cart observing the count next to Staff D. At 2:00 PM, when they finished the count finished, all three staff reported this as the normal process for counting controlled drugs. On 4/20/26 at 2:03 PM, the Director of Nursing (DON) reported that a staff member who just finished the controlled drug count reported they completed the count incorrectly. The DON reported staff didn't compare the bubble pack to the sheet to verify the correct drug, count, and resident. The DON reported she verbally educated the staff and planned to provide written education.	F0755		

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F0755 SS = D	Continued from page 2 Review of the facility reported incident investigation for missing controlled drugs on 10/31/25 documented Staff A, LPN, didn't sign the controlled drugs out at the time of giving the medication. The report documented Staff A gave Resident #2 a double dose of lorazepam (antianxiety medication). Resident #2 was missing another dose of lorazepam that was unaccounted for on 10/31/25. The facility's 5-day investigation documented Staff B, Registered Nurse (RN), was noted on video footage on 10/30/25 at 11:07 PM performing the controlled drug count. At 11:08 PM, Staff B punched out Resident #2's lorazepam and taped it into another resident's-controlled drug card. The investigation documented the staff's inaccurate reconciliation (matching records to actual supply) and count at shift change. Resident #2's Electronic Health Record (EHR) lacked documentation of the medication error in the chart. The chart lacked the controlled drug count sheet for October 2025 through November 2025 for the lorazepam. During an interview on 4/21/26 at 11:20 AM, the Administrator reported the controlled drug sheet for Resident #2's lorazepam during the medication discrepancy was missing. The Administrator reported staff have looked for it since the investigation but can't find it. During an interview on 4/21/26 at 12:15 PM, Staff A reported Staff F, CMA, performed the controlled drug count in the morning with Staff B. Staff A reported she didn't sign the controlled drugs out when she gave the medication. Staff A reported she went back later to sign them out and thought she didn't give Resident #2 his medication, so she gave him a dose around 8:00 PM. Staff A reported when she signed the book later, she realized she gave him another dose by mistake. Staff A reported she notified the physician (doctor). Staff A reported later when doing a count with Staff B, she noticed the controlled drug discrepancy. On 4/22/26 at 8:51 AM, the DON reported she couldn't find anything in the EHR documenting Resident #2's medication error and stated it should've been in the record. The undated Controlled Substances policy directed staff to reconcile controlled drugs upon receipt, administration, disposal, and at the end of each shift. The undated Medication Error-Incident Report	F0755		

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F0755 SS = D	Continued from page 3 Process policy directed staff that a medication error must be documented in the resident records and a medication error form must be filled out.	F0755		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure one of one residents (Resident #2) remained free from a medication error and failed to document the error in the clinical record. The facility reported a census of 23 residents. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated 3/9/26 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of Parkinson's disease (Brain disorder causing tremors, stiffness, and difficulty with movement), depression, and sleep apnea (A condition where breathing repeatedly stops and starts during sleep). The MDS documented he received an antianxiety medication during the 7-day lookback period. Review of the facility reported incident investigation for missing controlled drugs on 10/31/25 documented Staff A, Licensed Practical Nurse (LPN), didn't sign the controlled drugs record at the time of giving the controlled drug medication to ensure accurate documentation. The report documented Staff A gave Resident #2 a double the dose of lorazepam (an antianxiety medication). Resident #2's Electronic Health Record (EHR) lacked documentation of the medication error assessment and follow-up in the chart. On 4/21/26 at 12:15 PM, Staff A, Registered Nurse (RN) reported Staff F, Certified Medication Aide (CMA) performed the controlled drug (medications with a high potential for abuse) count in the morning with Staff B, RN. Staff A reported she didn't sign the controlled drugs out when she gave the	F0760	To remain in compliance with F0760, retrospective review of Resident #2's record revealed no evidence of adverse outcome. Late entry completed to address missing documentation; physician notified. Staff involved are no longer employed. No similar issues were found following facility-wide review of medication records. Medication administration policy reinforced, including the 5 rights and requirement to report and document all medication errors. Education provided to all nurses and CMAs with reinforcement of nurse oversight. DON/designee will complete random medication pass observations 2x/week x4 weeks, then monthly, with ongoing random MAR audits. Findings reviewed in QAPI.	

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F0760 SS = D	Continued from page 4 medication later that day. Staff A reported she went back later to sign the medication out as given and thought she didn't give Resident #2 his medication. Staff A then gave Resident #2 another dose around 8:00 PM. Staff A reported when she signed the book later, she realized she gave him another one by mistake. Staff A reported she notified the physician (doctor). Staff A reported later when doing a count with Staff B that she noticed the controlled drug discrepancy. On 4/22/26 at 8:51 AM, the Director of Nursing (DON) reported she couldn't find any information in the EHR documenting Resident #2's medication error, assessment, or follow-up in the chart and stated it should be there. The undated Medication Error-Incident Report Process policy directed staff a medication error must be documented in the resident records and to monitor for any adverse effects (unwanted or harmful results) caused by the error.	F0760		