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	165312	A. BUILDING _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FONDA SPECIALTY CARE	607 QUEEN STREET FONDA, IA 50540

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F 000	INITIAL COMMENTS The Centers for Medicare and Medicaid Services (CMS) conducted a comparative Federal Monitoring Survey (FMS) 3/17/25 through 3/21/25. Refer to State Survey Agency (SSA) Event ID HCNB11. Deficiencies were cited and 1 Facility Reported Incident (FRI) and 1complaint was investigated. Census: 41	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide services that meet professional standards of quality of care for 1 of 5 residents (R) reviewed for unnecessary medications (R21) when the facility failed to follow physician orders and notify the physician with a blood sugar (simple sugar in blood stream) greater than 400 milligrams per deciliter (mg/dL). Findings include: The facility policy titled Diabetes revised September 2017, stated physicians should help manage individuals with diabetes appropriately and effectively. Procedure revealed in pertinent part "the physician and staff would establish notification parameters related to diabetes	F 658	DON immediately educated Nurses on 03/26/25 on properly notifying physicians on Blood Sugars. R21 physician was notified on 03/26/25 on blood sugar. 3 Audits was conducted on 03/31/2025 by DON on Blood Sugar Notification to Physicians weekly X4 weeks or until substantial compliance is met. Audits will be reviewed during facilities monthly QAPI meeting for three months. Review of the audits will be completed by members of the QAPI committee to determine areas of improvement and revisions to maintain compliance.	03/26/25

Faith Epperson — 04/25/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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monitoring and based on the individualized notification parameters, the staff would inform the practitioner about the status of each patient's glucose control, depending on the situation, goals."

The Annual Minimum Data Set (MDS-federally mandated comprehensive assessment) for R21 dated 2/6/25, identified a Brief Interview of Mental Status (BIMS) score of 6, severe cognitive impairment. The MDS listed diagnoses of diabetes, hypertension, and Alzheimer's. The MDS recorded the resident received insulin injections daily in the last 7 days.

The Care Plan for R21 dated 10/6/23, identified the resident had a diabetes and an intervention included diabetes medication as ordered by the physician and monitor for and document side effects.
The Care plan for R21 revised 2/11/25, identified the resident with a diet order for regular/no added salt and at nutritional risk related to Alzheimer's, diabetes and an intervention to monitor blood sugars as ordered.

During an observation on 3/26/25 at 12:02 PM, License Practical Nurse (LPN1) checked R21's blood sugar with Registered Nurse 1 (RN1) observing. LPN1 obtained a blood sample, and the glucometer (monitor to check blood sugar) identified a blood sugar of 309 mg/dL. LPN1 proceeded to administer R21's insulin as ordered.

Review of the Physician Order sheet for R21, dated 2/20/25, included orders for:
-Accu check (blood sugar check) morning and bedtime, start date 9/5/23.
-Call physician if blood sugar less than 60 or

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greater than 400, start 4/8/24.
-Novolog insulin per sliding scale four times a day. If blood sugar 200-250 give 2 units, 251-300 give 4 units, 301-350 give 6 units, 351-400 give 8 units, and 401-450 give 10 units. Test blood sugar both midday and at bedtime and call if blood sugar over 401, start date 2/9/24.

Review of R21's Blood Sugar Summary dated 3/27/25, revealed the following:
-On 3/14/25 at 11:24 AM, 450 mg/dL
-On 3/7/25 at 11:49 AM, 423 mg/dL
-On 12/31/24 at 11:30 AM, 417 mg/dL

Review of R21's Progress Notes revealed:
-On 12/31/24 at 10:04 PM, the resident sat in the living room watching the television and attempted to put the newspaper in his mouth when the staff intervened.
-On 3/7/25 at 2:42 PM, notified the ARNP of the CBC (lab, complete blood count) drawn on 3/4/25, being overlooked and faxed for a second time to review and no new orders.

Review of R21's clinical record lacked documentation of physician notification when the resident's blood sugars were greater than 400 mg/dl on 3/14/25, 3/7/25, and 12/31/24.

During an interview on 3/27/25 at 11:00 AM, the Director of Nursing (DON) stated physician notifications related to R21's blood sugars would be documented in the resident's progress notes.
During an interview on 3/27/25 at 12:20 PM, the Advanced Registered Nurse Practitioner (ARNP) stated she had been covering the facility off and on the last month with a couple other ARNP's. The ARNP stated she would receive phone calls or faxes, mainly phone calls, with resident

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F 658	Continued From page 3 notifications. The ARNP stated she did recall the facility had called her on March 7th and she had ordered labs and a urinalysis (UA) due to R21's high blood sugars. The ARNP proceeded to state R21's sliding scale went high enough to cover blood sugars over 400 mg/dL. The ARNP stated she could confirm from the call box on her cell phone, that the facility called her multiple times on March 7th and the 11th, however, did not know what they had called her about. The ARNP stated she did not have a call from the facility on March 14th. Jointly reviewed R21's progress notes dated 3/7/25, and the ARNP stated she had reviewed labs that were sent to her on 3/7/25 and acknowledged there was no mention of the resident's blood sugars. The ARNP stated with R21's sliding scale covering blood sugars over 400 mg/dL, she would expect the nursing staff to document in the progress notes that they had notified her and document no new orders or "whatever I said." During an interview on 3/27/25 at 12:44 PM, the DON stated she would expect the nurses to follow physician orders and would expect the nurses to document in the progress notes when physicians were notified.	F 658		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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F 689	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to adequately supervise residents to prevent falls for 1 of 3 residents (R) reviewed for falls (R13), failed to supervise residents during medication administration (R12 and R10), and failed to store equipment in a safe manner. Specifically, the facility failed to: -thoroughly investigate falls, implement and/or revise interventions to prevent further falls, to follow the care plan and/or fall interventions implemented for R13 who had intermittent confusion, and a history of falls related to self-transfers. R13 was found on the floor on 9/16/24 and on 11/13/24. The facility failed to complete an assessment at the time, follow-up assessments, and/or investigate the cause. On 11/16/24, R13 was transferred to the local emergency room (ER) for right hip pain and required transfer to another hospital for surgical repair of a right hip fracture. -supervise residents during medication administration. -ensure the residents' environment remained as free of accident hazards as was possible when staff stored resident equipment in the facility hallways, limiting independent residents ability to safely maneuver throughout the facility. Findings include: 1. The Significant Change in Status (SCSA) Minimum Data Set (MDS-federally mandated comprehensive assessment) for R13 dated 9/5/24, identified a Brief Interview of Mental Status (BIMS) score of 5, severe cognitive	F 689	All fall care plans and interventions were reviewed on 04/24/25 to ensure proper interventions are in place and if revising is necessary. R13 care plan and interventions were reviewed and revised to ensure adequate interventions are in place on 04/24/25 All residents have the potential to be affected by this. All nursing staff were educated by DON on Care Plans and Fall Assessments on 04/17/25 Fall Assessment Audit and Care Plan 3 Audits X 4 weeks then 1 audit x 4 weeks by DON on 03/31/25 or until substantial compliance is met. Results submitted to QA for review All Nursing staff who administer medications were immediately educated on proper medication administration procedures by DON on 03/26/25	04/24/25

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F 689	Continued From page 5 impairment. The MDS coded the resident to have physical and verbal behavior directed towards others and refused care 1 to 3 days in the last 7 days. The MDS identified the resident behaviors being worse. The MDS revealed the resident was dependent on staff for toileting, partial/moderate assistance for bed mobility and transfers, and did not attempt to ambulate. The resident utilized a wheelchair and was dependent on staff for locomotion. The MDS coded the resident being frequently incontinent of urine and continent of bowel and no toileting program. The MDS documented diagnoses of Alzheimer's disease, dementia with severe agitation, Parkinson's, anxiety, depression, and bipolar disorder. The MDS coded the resident had one fall with no injury since prior assessment. The SCSA MDS for R13 dated 11/25/24, identified a BIMS score of 12, moderate cognitive impairment. The MDS coded the resident as refusing care 1-3 days in the last 7 days, with an improvement in behaviors. The MDS revealed the resident was dependent on staff for toileting, bed mobility, and transfers, and did not attempt to ambulate. The resident utilized a wheelchair and was dependent on staff for locomotion. The MDS coded the resident being continent of urine and frequently incontinent of bowel and no toileting program. The MDS documented diagnoses of hip fracture, Alzheimer's disease, Parkinson's, anxiety, depression, and bipolar disorder. The MDS coded the resident had no falls since prior assessment. The Care Plan for R13 revised 6/11/24, identified the resident had an actual fall. The care plan interventions included: -urinal in reach and encouraged to use (8/17/23)	F 689	R12 and R10 care plan was reviewed to ensure medication monitoring on administration on 04/18/25 All residents have the potential to be affected by this. Medication administration 3 Audits X 4 weeks then 1 audit x 4 weeks was started on 03/31/25 until substantial compliance is met. Audits will be reviewed during facilities monthly QAPI meeting for three months. Review of the audits will be completed by members of the QAPI committee to determine areas of improvement and revisions to maintain compliance. All equipment and devices were stored in storage rooms down short and long hall on 04/24/25 All residents had the potential to be affected by this. All employees were educated by ADM on proper storage of equipment on 04/24/25 Equipment storage audit was conducted by Administrator on 04/24/25 weekly x 4 weeks until substantial compliance is met. Audits will be reviewed during facilities monthly QAPI meeting for three months. Review of the audits will be completed by members of the QAPI committee to determine areas of improvement and revisions to maintain compliance.	04/24/25

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F 689	Continued From page 6 -bed in low position (9/15/23) -bolster overlay to assist with edge definition (6/10/24) -educate staff to fold walker and store when not in use (4/9/24) -encourage that behavior sliding out of bed is not safe (9/9/24) -encourage to use call light for assistance (8/18/23) -encourage to keep items in upper drawer to prevent bending over (10/8/23) -staff to frequently check positioning during the night to ensure not too close to edge (7/17/24) -bedside table in reach with remote when in room (3/31/24) The Care Plan for R13 dated 10/13/23, identified the resident required assistance with activities of daily living (ADL's). The care plan interventions included: ambulation with front wheeled walker with assist of one followed by wheelchair, dependent on one staff for bed mobility, dependent on two staff for toileting, and assist of two staff with pivot transfer and wheeled walker. The Care Plan for R13 dated 10/17/23, identified the resident was resistive to care related to dementia. The care plan interventions included: -a history of self-transforming self rather than ask for help (10/15/24) -at times refused to sleep in bed and preferred to sleep in recliner, reclining wheelchair (10/18/24) -at times preferred to sleep through meals (11/19/24) During an observation on 3/25/25 at 8:26 AM, R13 was lying in bed with eyes closed, heels elevated on pillow, tray table beside with personal items, call light in reach, an empty cup holder	F 689		

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attached to side of the bed, and wedge on shelf beside bed. No lipped mattress, no bed bolster in place, and bed not lowered to the floor. The resident does not respond after multiple attempts to awaken.

During an observation on 3/25/25 9:15 AM, R13 remained in bed with eyes closed and did not respond when spoken to. Bed not lowered to the floor, no lipped mattress, and no boundary placement at edges of mattress.

During an observation on 3/25/25 at 9:41 AM, R13 in Broda chair (type of wheelchair used to provide supportive positioning through tilt and recline), in lobby area having hot chocolate with fellow residents.

During a concurrent observation and interview on 3/25/25 at 11:30 AM, R13 in Broda chair, in room with feet elevated, tray table beside chair, and call light in reach. R13 stated he had broken his hip when he fell out of bed and staff helped him up. The resident then stated his hip broke when staff were "standing there." R13 proceeded to say, "they don't give a sh*t, just pushed on my hip." R13 stated he did not have his current roommate at the time he had fractured his hip.

During an observation on 3/27/25 at 9:14 AM, Nurse Aide 1 (NA1) ambulated R13 to the bathroom with gait belt and walker, gait slow and shuffling feet. R13 voiced no complaints of pain with ambulation. R13 stated he needed to sit for a while and NA1 encouraged the resident to use call light when done.

During an observation on 3/27/25 at 9:30 AM, NA2 and NA3 attempted to ambulate R13 out of

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the bathroom with walker and gait belt, however, the resident had increased difficulty with lower extremities shaking and unable to take steps forward. NA2 and NA3 assisted R13 to sit back down on the toilet and brought Broda chair into the bathroom and the staff transferred the resident to the Broda chair with walker and gait belt. R13 voiced no complaints of pain. NA2 and NA3 placed R13 in front of the television, wedge placed under right arm, feel elevated and pillow placed under legs, call light and tray table within reach.

During an observation and concurrent interview on 3/27/25 9:50 AM, R13 was up in Broda chair, in room, with legs elevated and heels floating on pillow. Call light and tray table within reach, and no urinal in reach. Questioned R13 about crawling on floor in his room and stated he was "just trying to get up after I fell." Questioned R13 if he was attempting to use the bathroom, "why the h*ll would you ask me that."

During an observation on 3/28/25 at 7:35 AM, R13 was in bed and eyes closed. Cup holder on the side of the bed contained urinal and call light in reach. No lipped or scooped mattress and no bed bolster in place.

The Progress Notes for R13 revealed:

-On 9/9/24, resident seen by physician. Noted the resident transitioned off hospice on 8/31/24 and was not on Sinemet (used to treat Parkinson symptoms) while on hospice and has slow gait and slow initiation of movement. Attempt to improve fall risk and start low dose of Sinemet and stop high risk fentanyl patch (narcotic pain medication) which is likely to contribute to falls.

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F 689	Continued From page 9 -On 9/9/24 at 5:07 AM, as nurse entered resident room, the resident slid onto the floor from the edge of his bed. The resident stated he was going to fly. The resident denied the need to use the bathroom. Range of motion within normal limits, denied pain, and stood with assist of two staff and gait belt. The resident had gripper socks on, bed was in low position, call light in reach, the resident was continent, floor free of clutter, and light appropriate for time of day. The resident had been checked on rounds at 1:00 AM and was incontinent. Notified the family and physician. -On 9/9/24 at 2:53 PM, focused evaluation, the resident had no complaints of discomfort due to sliding out of bed. -On 9/9/24 at 9:26 PM, focused evaluation, the resident without new injury noted or reported related to previous witnessed fall. Resident ambulates down the hall with walker and assist of one with difficulty. Denies pain or discomfort. -On 9/10/24 at 5:01 PM, focused evaluation, monitoring resident due to recent witnessed fall. No injuries noted at this time. -On 9/11/24 at 2:54 AM, focused evaluation, the resident without new injury noted or reported related to previous witnessed fall. Resident ambulates down hall with walker and assist of one without difficulty. Resident denies pain or discomfort. -On 9/11/24 at 1:24 PM, focused evaluation, active range of motion, no injury noted and denies pain.	F 689		

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-On 9/16/24 at 1:52 PM, the resident was found crawling on the floor in room, wanting something out of his closet. The resident was encouraged to call for help and the resident laughed. Vital signs stable and the resident was assisted into chair.

-On 9/18/24 at 10:05 AM, care plan conference note, identified fall concerns related to sliding off side of bed.

-On 9/26/24 seen by the physician and noted the resident was transitioned off hospice services on 8/31/24 and started on Sinemet. The resident has been attending more activities, walks to and from meals and been more interactive. With response to treatment, the resident agreed to higher dose.

-On 11/13/24 at 1:13 AM, focused evaluation related to resident being monitored due to antibiotic use to treat urinary tract infection (UTI). Resident alert and orientated and able to voice concerns. No signs or symptoms of adverse effect and will continue to monitor.

-On 11/13/24 11:52 AM, focused evaluation related to resident being on antibiotic for UTI. No adverse reaction, fluids encouraged and tolerates well. The resident denied dysuria (pain with urination).

-On 11/13/24 8:36 PM, late entry, the resident was found crawling on the floor. The resident stated he needed to his walker to go to the bathroom. The walker was by the television and when asked about using call light beside him, the resident stated he did not need help. Two staff assisted the resident up and to the bathroom. The resident was encouraged to use call light.

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-On 11/14/24 4:46 AM, late entry, the resident on antibiotic for UTI. Vital signs within normal limits. No adverse reactions reported, and the resident has no new concerns.

-On 11/14/24 5:44 AM, resident had only a small or no bowel movement every shift for 72 hours. Resident refused a suppository, bowel sounds present all 4 quadrants, and stomach soft.

-On 11/15/24 5:47 PM, the resident has not had a bowel movement. Bowel sounds active in all 4 quadrants, vital signs stable and resident resting in bed. The resident speaks when spoken to but refused to get up for supper. The resident's provider was updated.

-On 11/16/24 at 5:21 AM, the resident opened his eyes when checked on rounds and answered questions appropriately. Vital signs within normal limits and the resident had no signs or symptoms of pain or discomfort.

-On 11/16/24 at 5:34 AM, the resident complained of right hip, leg, and back pain, and as needed pain medication was given.

-On 11/16/24 at 5:36 AM, the resident had only a small, or no bowel movement documented every shift for 72 hours. The resident refused suppository. Bowel sounds active in all 4 quadrants, stomach soft and slightly distended.

-On 11/16/24 at 4:00 PM, the local hospital was called, and the resident being transferred to another hospital due to right hip fracture.

-On 11/16/24 4:50 PM, change in condition reported to provider due to pain that was

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uncontrolled and was different than usual. The provider responded and recommended send the resident to the emergency room for evaluation and treatment.

-On 11/16/24 5:34 PM, the resident out of the facility via facility van to the local emergency room

-On 11/16/24 at 6:32 PM, the resident was up for breakfast and lunch, assist x 2 with easy stand (mechanical lift). Resident had increased complaints of pain to right hip has shift progressed. Notified the resident's provider and order received to transfer to the local emergency room for evaluation and treatment due to increased pain.

-On 11/16/24 9:24 PM, the resident was in his room in recliner, complaining of pain in right hip. Resident assessed and resident complained of increased right hip pain with range of motion. Spoke with nurse and resident sent out for x-ray.

-On 11/19/24 at 7:23 PM, the resident returned to the facility via ambulance, alert and orientated x 2. Right hip fracture.

Review of the Focused Evaluations for R13 dated 11/13/24 through 11/16/24, revealed hot charting completed due to monitoring for antibiotic use. The assessments included vital signs, and an update narrative related to the antibiotic use and the resident's urinary tract infection.

Review of the Fall Risk Evaluations for R13 stated a total score of 10 or above, represented a high risk for falls.

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F 689	Continued From page 13 -On 7/3/24, score of 15. Due to intermittent confusion, 3 or more falls in the past 3 months, takes 3-4 high risk medications, and 1-2 predisposing factors. -On 9/5/24, score 11. Due to intermittent confusion, 1-2 falls in the past 3 months, takes 1-2 high risk medications, and 1-2 predisposing factors. -On 9/9/24, score 10. Due to 3 or more falls in the past 3 months and takes 1-2 high risk medications. -On 11/20/24, score of 10. Due to 3 or more falls past 3 months, takes 1-2 high risk medications, and 1-2 predisposing factors. The clinical record review lacked incident reports and/or investigations and assessments related to R13 being found on the floor on 9/16/24 and 11/13/24. Emergency Department Provider Note dated 11/16/24 at 6:17 PM, stated R13 presented with right hip pain, new problem that started today. R13 from care facility and the nurse did not notice any fall. Moderate right hip pain localized in a joint and symptoms are relieved by one or more prescription drugs. -Physical Exam, Musculoskeletal: tenderness and decreased range of motion to right hip with right lower extremity external rotation. -Right hip and pelvis X-ray: minimally displaced subcapital fracture of the right hip (break in the neck of the thighbone) -Final diagnosis: closed fracture of right hip. -Plan: transfer	F 689		

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Medicine History and Physical dated 11/16/24 at 10:17 PM, stated R13 was an accepted transfer by orthopedic surgery. The resident's baseline dementia, mechanism of injury unclear, likely presumed fall at the care facility versus other etiology. Orthopedic surgery plans operating room in the morning.

The facility policy titled Assessing Falls and Their Causes revised March 2018, stated the purpose of the procedure was to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. The policy revealed in pertinent part:
- "If a resident fell or was found on the floor without a witness to the event, evaluate the resident for possible injury"
- "Obtain and record vital signs"
- "Notify the resident's physician and family"
- "Document any observed signs or symptoms of pain, swelling, bruising, deformity, and /or decreased mobility, and any changes in level of consciousness"
- "Document the incident in the risk management system for resident falls no later than 24 hours after the fall occurs"
- "After an observed fall, begin to try to identify possible or likely causes of the incident"
- "Evaluate time of day of the fall, time of last meal, what the resident was doing, was the resident alone, was the resident trying to get to the bathroom, other environmental factors involved, and if there was a pattern of falls for the resident"
- "Documentation should include condition resident was found; assessment data, including vital signs and injury; interventions, first aid or treatment administered; notification of physician and family; completion of risk assessment; and

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appropriate interventions to prevent future falls."

During an interview on 3/27/25 at 9:14 AM, NA1 stated she had been at the facility since the end of December. NA1 stated she had never witnessed R13 put himself on the floor nor had she witnessed him crawl on the floor. NA1 stated R13 was "really good" about using his call light for assistance to use the bathroom.

During an interview on 3/27/25 at 9:40 AM, NA3 stated he had worked at the facility for a year and a half. NA3 stated there were times R13 would attempt to stand to self-transfer himself. NA3 stated R13 worked with therapy and has started to walk again and thinks he is able to ambulate by himself. NA3 stated he had never found R13 on the floor. NA3 stated if he observed R13 attempting to self-transfer he would attempt talk to the resident and remind him of the need for assistance and notify the nurse. NA3 stated the staff completed frequent checks on R13 throughout the day and the resident preferred to be up in chair during day.

During an interview on 3/27/25 at 9:43 AM, NA2 stated she had worked at the facility for three years. NA2 stated R13 attempted to self-transfer "all the time," and was "ornery sometimes." NA2 stated when R13 must have bowel movement, he thinks he can do it by himself and that he does not need assistance. NA2 stated staff attempt to re-direct R13 when they find him standing beside his bed or chair. NA2 stated there were times R13 would not use the call light and staff would "catch" him trying to stand up by himself. NA2 stated the interventions in place to prevent falls included: encourage use of call light, call light in reach, frequent checks, and bed lowered to the

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floor. NA2 stated she was not aware of the use of a bed wedge, lipped mattress, or boundary pillow. NA2 stated she had observed R13 up on all fours on the floor, however, not crawling on the floor, and the resident had informed her he needed to use the bathroom. NA2 stated when R13 self-transferred it was related to the need to use the bathroom. NA2 stated there were days R13 felt strong and wanted to walk and staff would assist him to satisfy his need.

During an interview on 3/27/25 at 11:49 AM, NA4 stated she had worked at the facility for approximately six months. NA4 confirmed she had been working on 11/13/24, when R13 was found on the floor in his room. NA4 stated her shift started at 10:00 PM on 11/13/24, however, she is required to be at the facility early to prepare her supplies. NA4 stated she could not recall what time R13 was found on the floor. NA4 stated she did not find R13, however, had been there to assist the resident up. NA4 stated R13's call light was on and had been within reach when he was found on the floor on 11/13/24. NA4 stated she did not know how R13 got on the floor that he had been in his chair, however, "I thought he fell out of his chair." NA4 stated R13 did not say how he fell, just that he was crawling from his chair. NA4 stated she "thought" the nurse checked R13's vital signs and asked him if he was having pain, however, did not recall if the nurse assessed the resident's range of motion. NA4 stated if a resident was found on the floor, alert the nurse immediately and wait to assist the resident up. NA4 stated R13 was encouraged to use his call light, however, he does attempt to self-transfer. NA4 stated R13 preferred to sleep in his chair, however, the staff would encourage him to lay in bed at night. NA4 stated R13 would

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use his call light when he needed to use the bathroom, however, during the night, staff would check him on rounds twice during the night and offer the bathroom or check and change him.

During an interview on 3/27/25 at 1:42 PM, NA5 confirmed she worked 2PM-10PM on 11/13/24, the night R13 was found on the floor. NA5 stated she found out about the incident after the resident was back in his Broda chair and was unsure of when the incident occurred. NA5 stated she was not aware the last time R13 had been toileted and/or changed prior to being found on the floor. NA5 stated R13 could propel himself if he was in a regular wheelchair and he could propel self around and when not in the regular wheelchair, would be in the recliner. NA5 stated there were times R13 would refuse to go to bed and sleep in the recliner. NA5 stated when R13 refused to go to bed at night, after multiple attempts, would alert the night shift they would attempt to get the resident in bed. NA5 stated R13 would use the call light and at times would find the resident standing up on his own. NA5 stated when she would find R13 standing on his own she would educate him to use his call light. NA5 stated she was unaware of why R13 would stand and/or self-transfer, at times would say he was stretching legs and other times would say he had to go to the bathroom. NA5 stated she never found the resident on floor. NA5 stated when a resident falls or found on the floor do not move the resident and call the nurse to evaluate the resident. NA5 stated interventions to prevent R13 from falls included: call light and Broda with chair feet up. NA5 stated she had never witnessed R13 attempt to get out of bed on own. NA5 stated she believed R13 used to have mattress with lip when he was on hospice, however, removed once

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graduated from hospice. NA5 stated R13's bed was to be lowered but not all the way to the floor. NA5 stated R13 would alert staff when he had to go to the bathroom by call light. NA5 stated in the past when R13 lost his call light he would holler out for staff assistance.

During an interview on 3/27/25 at 2:03 PM, NA6 stated she had worked at the facility for approximately seven months and confirmed she worked 10 PM-6AM on 11/13/24 when R13 was found on floor. NA6 stated she arrived at work around 9:00 PM to prepare supplies for the night shift prior to the 2PM-10PM shift leaving, however, did not recall what time the incident occurred. NA6 stated she R13 was in his recliner when she arrived at work. NA6 stated she did not find the resident on the floor, however, thought she had assisted with getting him up off the floor. NA6 stated she "thought" the nurse had assessed the resident and checked his blood pressure prior to assisting him off the floor. NA6 stated R13 was checked on during rounds at night and if he wanted to use the bathroom, staff would assist him to the bathroom. If R13 was sleeping during rounds, staff would awaken him to check and change or take him to the bathroom. NA6 stated there were times R13 would refuse to get up to bathroom and refuse to be changed and they would alert the nurse. NA6 stated R13 was to have bed in low position, not to the floor, and call light in reach. NA6 stated she did not recall if R13 had a lipped mattress.

During an interview on 3/27/25 at 2:26 PM, CMA2 confirmed she had worked 2PM-10PM on 11/13/24 when R13 was found on the floor. CMA2 stated she believed the incident occurred before bedtime but after supper, observed the R13

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crawling on his room floor as she was walking down the hall. CMA2 stated Licensed Practical Nurse 2 (LPN2) was notified and came in to assess the resident. CMA2 stated she left the room and LPN2 assisted R13 to the bathroom. CMA2 stated she did not recall when the resident was last toileted on the night of 11/13/24. CMA2 stated R13 was "stubborn and in his ways," however, he would utilize call light when he had to go to the bathroom. CMA2 stated at the time of the fall R13 would use his call light, ambulate to the bathroom with one assist and would go to bed when he was ready. CMA2 stated there were times, previously and now, that R13 would try and stand without calling for assist and staff must keep an eye on him as going by his room. CMA2 stated R13 could get "antsy," and staff had to keep an eye on him. CMA2 stated R13 was to have call light in reach and bed in low position, but not to the floor because would then be unable to get out. CMA2 stated she did not know if R13 had a scooped mattress.

During an interview on 3/27/25 at 2:34 PM, RN2 stated she had worked at the facility for two years and off/on for ten years. RN2 stated when a resident was found on the floor, consider a fall due to being unwitnessed, obtain vital signs would be obtained, an assessment including pain and range of motion, interview resident and staff, update family and physician, and send to the hospital if needed. RN2 stated document and monitor the resident per protocol, focused evaluation completed every shift for 72 hours. RN2 stated with a focused evaluation, you specify what you are monitoring or following up on, fall, antibiotic use, or hospitalization. RN2 stated R13 is to have call light in reach, proper footwear, confirm needs are met such as toileted, ambulate

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to/from meals, and bedside table in reach. RN2 stated R13 was on hospice and previously had scooped mattress. RN2 stated R13 would go "forever without pooping," and felt that contributed to his fall on 11/13/24, "we do everything we can for him, and he just has trouble pooping." RN2 stated R13 would turn call light on to go to the bathroom on good days and staff needed to answer right away, however, R13 would also try and get up without staff assistance.

During a follow-up interview on 3/27/25 at 2:41 PM, CMA2 stated she went and checked, R13 had a regular mattress on his bed.

During an interview on 3/27/25 at 3:50 PM, LPN2 stated she had worked at the facility for two and a half years and confirmed she was working 6PM-6AM when R13 was found on the floor. LPN2 stated she did not know exactly what time the incident occurred; however, she was doing blood sugars across the hall and would have been around 8:00 PM or before. LPN2 stated R13's call light was not on when she entered the room across the hall to complete blood sugars, however, did not recall visually seeing the resident prior to entering the room across the hall. LPN2 stated she did not know if R13 was toileted when he was taken to his room after supper and did not know what staff assisted him to his room after supper. LPN2 stated all residents were to be out of the dining room by 7:15 PM so the smokers could be taken out and R13 was one of the last residents that left the dining room. LPN2 stated she did not know when R13 was last toileted, however, staff tried to toilet all residents before supper and then before bed. LPN2 stated CMA2 had found R13 on all fours in front of his recliner. LPN2 stated when she asked R13 what

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he was doing, and he had said he had to go to the bathroom and was going to the bathroom. LPN2 stated she assisted R13 to stand with gait belt and assist from CMA2 and asked him if he was in pain while she had him march in place. R13 was assisted into the recliner and LPN2 stated she proceeded to perform range of motion to lower legs and R13 denied pain, so she then assisted him to ambulate into the bathroom. LPN2 stated R13 denied any pain and ambulated back to the recliner after using the bathroom. LPN2 stated R13 was back to the recliner she hooked the call light to the recliner and educated the resident not to crawl on the floor. LPN2 stated she had checked on R13 throughout the night, staff completed check and change, and the resident had complained of back pain during the night. LPN2 stated she did not complete an incident report when she found R13 on the floor on 11/13/24 and did not document her assessment. LPN2 stated two months prior she had observed R13 physically put himself on the floor and had completed the fall packet (paperwork) and had been informed that she did not need to complete the fall packet because the resident was care planned to crawl on his floor. LPN2 stated there was a communication error, because after the incident on 11/13/24, she was informed she had to observe R13 putting himself on floor to not be considered a fall. LPN2 stated if she found a resident on the floor it was to be considered a fall and needed to complete the fall packet. LPN2 stated the facility did complete education for the nursing staff related to finding residents on the floor and completing the fall packet. LPN2 stated she did not know if R13 fell from the recliner or if he put himself on the floor, the resident told me he was getting himself to the bathroom. LPN2 stated R13 wanted to be

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independent and would "usually" use call light when he needed to go to the bathroom, however, at times when stand up without assist from staff. LPN2 stated R13 was to have call light in reach, bed in low position, gripper socks, and walker put away. LPN2 stated R13 had a scoop mattress when on hospice, however, was not sure he had anymore.

During an interview on 3/28/25 at 8:28 AM, NA7 stated she had worked 2PM-10PM on 11/13/24 when R13 was found on the floor. NA7 stated all residents were to be toileted and/or changed before supper, when returning to room after supper and, before bed. NA7 stated she did not know when the last time R13 was toileted on 11/13/24, or who took him to his room after supper. NA7 stated there were times R13 would refuse to go to the bathroom and refused to be changed, however staff would continue to offer. NA7 stated R13 was "pretty with it in November and he knew he when he needed to go to bathroom, and we would take him."

During a concurrent interview and record review on 3/28/25 at 8:46 AM, the Director of Nursing (DON) stated a fall was when a resident fell to the floor, was found on the floor, or when there was a break in the plane, when a resident was standing and went to their knees. The DON stated R13 was care planned to crawl on his floor, due to getting out of bed and getting items out of his drawers. Reviewed the facility fall policy regarding fall being defined as found on the floor without a witness, and the DON stated the nurse had informed her that R13 was care planned to be on the floor, and he was on the floor crawling, the nurse did not consider it a fall. The DON stated the resident had to be observed putting himself

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on the floor, not to be considered a fall and due to the incident on 11/13/24, education was provided to the nursing staff that if a resident was found on the floor it would be considered a fall. Reviewed R13's progress note dated 9/16/24 when the resident was found on the floor and the DON stated she was sure the resident told the staff he put himself on the floor. The DON stated by the care plan the incident on 9/16/24 would not be considered a fall because R13 was care planned that he could crawl on floor to get items out of his drawer. The DON confirmed R13 could have fallen on the floor, however, did not know. The DON stated the nurse on 11/13/24 would have to explain why no fall assessment and/or incident report was completed when R13 was found on the floor and how that decision was made. The DON stated at times R13 was with it and other times he was not, may or may not get a correct answer on how he got to the floor. Reviewed R13's care plan, including fall interventions and the DON stated when resident graduated from hospice, hospice took the mattress and wheelchair, and the facility missed putting the correct mattress back on. The DON stated R13 could turn on his call light when he needed to go to the bathroom, was incontinent at times and staff would check on him. The DON stated the staff would have to assist R13 with using the urinal, that she did not think he would be able to use the urinal independently. Questioned the DON if having the urinal within reach was an effective fall intervention if the resident was unable to use independently and she said she would have to ask the nursing staff due to not being sure how often the urinal was used. The DON stated after R13 was found on the floor on 11/13/24 he ambulated to/from the bathroom and did not complain of pain. The DON stated she felt

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the fall assessments were completed at the time of the fall with range of motion being completed, however, confirmed there was no documentation in R13 medical record. The DON stated the R13 had assessments completed every shift for three days following the fall on the focused evaluations and confirmed the focused evaluations were being completed due to the resident being on an antibiotic for a urinary tract infection.

During a concurrent interview and record review on 3/28/25 at 9:13 AM, the Administrator stated that on 9/16/24 and 11/13/24 when R13 was found on the floor fall assessments and/or incident reports should have been completed due to being unwitnessed. The Administrator stated the DON did provide education to all nursing staff after the incident on 11/13/24 regarding what was considered a fall and how to do an assessment. The Administrator stated falls were reviewed daily in clinical meetings, risk assessments reviewed, what occurred related to the fall, precautions in place, and what interventions to prevent further falls. The Administrator stated staff reviewed resident's fall interventions during care plans or when the resident had a fall, and interventions were changed and/or added as needed.

During a follow-up interview on 3/28/25 at 9:46 AM, the Administrator stated the facility had a PIP (Performance Improvement Plan) implemented for falls in December and would be revisiting the plan to make adjustments.

2. The Quarterly MDS for R12 dated 3/6/25, identified a BIMS score of 14, no cognitive impairment. The MDS coded the resident to have other behavioral symptoms not directed toward others (physical symptoms such as hitting or

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scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) 1 to 3 days in the last 7 days. The MDS documented diagnoses of anxiety, depression, and paranoid schizophrenia. The MDS coded the resident taking antipsychotics (treat psychotic disorders by blocking the effects of dopamine in the brain), antianxiety (treat anxiety, work by calming the brain), and antidepressant (treat depression by increasing the levels of certain neurotransmitters in the brain) medications in the last 7 days.

The Care Plan for R12 revised 2/9/24 identified the resident took medication related to mental health diagnosis. The care plan intervention included the resident preferred to not have nursing stand right over her and watching her take her medications, the nurse/med aide would stand at a distance to assure that medications were taken.

The Care Plan for R12 revised 3/24/20, identified the resident had a behavior problem related to insecurity and lack of trust/delusions from schizophrenia. The care plan intervention included staff to talk with resident prior to changing any form of medication as the resident knows the pills by appearance and imprint, reassure that the medications are ordered by provider.

The Medication Administration Record (MAR) for R12 dated March 2025 included the following medications administered during the morning medication pass:
-Bisacodyl (laxative) tablet 5 milligrams (mg) daily for constipation

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F 689	Continued From page 26 -Colace (laxative) capsule 100mg, 2 capsules daily for constipation -MiraLAX (laxative) 17 grams daily for constipation -Haldol (antipsychotic) 5 mg, 3 tablets daily for paranoia -multivitamin daily for supplement -senna plus (laxative) 8.5-50 mg 1 tablet daily for constipation -sertraline (antidepressant) 50 mg daily for major depression -lorazepam (antianxiety) 1 mg two times a day for anxiety -benztropine (anti-tremor, used to treat side effects of antipsychotics) 1 mg three times a day for paranoid schizophrenia -acetaminophen 325 mg 1 tablet every 4 hours as needed for pain 3. The Quarterly MDS dated 2/13/25 for R10, identified a BIMS score of 15, no cognitive impairment. The MDS coded the resident to refuse care 1 to 3 days in the last 7 days. The MDS documented diagnoses of anxiety, depression, and paranoid schizophrenia. The MDS coded the resident taking antipsychotics, antianxiety, and antidepressant medications in the last 7 days. The Care Plan revised 10/27/22 for R10 identified the resident had an alteration in behavior/occasional anger with staff and other resident verbally accusing others related to diagnosis of paranoid schizophrenia. The care plan intervention included the resident checked numbers on medications and becomes upset if they change. The Care Plan revised 12/28/23 for R10 identified	F 689		

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the resident was at risk for side effects from antianxiety medication use. The care plan intervention stated the resident preferred when receiving medications that nursing did not stand over him while taking medications and that the nurse/med aide would stand at a distance to assure that medications were taken.

The MAR for R10 dated March 2025 included the following medications administered during the morning medication pass:
-Finasteride 5 mg daily for enlarged prostate
-Haldol 10 mg daily for paranoid schizophrenia
-MiraLAX powder 17 grams daily for constipation
-multivitamin daily for supplement
-senna plus 8.6/50 mg 1 tablet daily for constipation
-sertraline 25 mg daily for major depression
-benztropine 0.5 mg two times a day for extrapyramidal movements (tremors)
-lorazepam 0.5 mg two times a day for anxiety

During an observation on 3/26/25 from 8:06 - 8:12 AM, Certified Medication Aide 1 (CMA1) prepared and administered R12 and R10's morning medications while in the dining room. After CMA1 handed the medication cups, with the resident's morning medications, to R12 and R10, CMA1 exited the dining room.
-at 8:18 AM, two nurse aides (NA's) were behind R12 and R10 assisting fellow residents with eating. One of the NA's had their back to R12 and R10 and the other NA did not have a clear view of R12 or R10.
-at 8:26 AM, R12 laid her medications out on a napkin and the powder MiraLAX continued to be in a small clear medicine cup. R10's medications were laid out on a napkin as well, however, the small clear medicine cup that had MiraLAX was

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empty.
-at 8:27 AM, the dietary staff provided R12 and R10 their breakfast.
-at 8:28 AM, CMA1 returned to the dining room while R10 and R12 continued to have various medications laid out on napkins on the table.

The facility policy titled Administering Medications revised April 2019, stated medications were to be administered in a safe and timely manner, and as prescribed. The Policy Interpretation and Implementation stated in pertinent part "residents may self-administer their own medications only if the physician with the Interdisciplinary Team had determined the residents had the decision-making capacity to do so safely.

During an interview on 3/26/25 at 1:54 PM, CMA2 stated R12 and R10 were "very suspicious about their medications and knew their medications by size, shape, color, and/or number." CMA2 stated R10 would shake capsules to confirm they contained granules prior to taking. CMA2 stated when she would administer medications to R12 and R10 she would stand back from the residents, however, continue to observe to confirm the resident took their medications. CMA2 stated when R12 and R10 received their medications in their rooms, she would stay in the rooms until the residents took their medications.

During an interview on 3/26/25 at 1:55 PM, CMA1 stated he was to supervise R12 and R10 until they took their medications. CMA1 stated at lunch the R12 and R10 preferred to take their medications in their rooms, and he would stay until they had taken their medications. CMA1 confirmed he left the dining room during morning medication administration prior to R12 and R10

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taking their medications. CMA1 stated there were four other CMA's working as NA's on the floor and were in the dining room at the time. CMA1 stated R12 and R10 were paranoid and would get more paranoid when the staff observed them taking their medications. CMA1 stated R12 and R10 had questioned why the Regional Office Surveyor watched CMA1 prepare and administer their medications. CMA1 stated he felt it was a fine line while caring for the resident's and respecting their boundaries. CMA1 stated he was not aware of R12 or R10 having an assessment to self-administer their medications.

During an interview on 3/27/25 at 11:04 AM, the DON stated she was not aware of R12 or R10 having an assessment to self-administrator their medications. The DON stated CMA1 should have remained in the dining room after providing R12 and R10 their medications.

During an interview on 3/27/25 at 11:06 AM, the Vice President (VP) of Corporate Compliance stated the self-administration assessment would be completed for residents that kept medications at bedside and self-administered, not for residents that staff are to stand back and watch the residents take their medications. The VP of Corporate Compliance stated they would want oversight that the medications were taken.

4. Observation on 3/25/25 at 10:30AM revealed that the long hall with the lower numbered rooms had a large amount of equipment stored on the hall. Equipment lined up on one side of the hall included two mechanical lifts, two walkers, one Broda (larger specialty transport chairs) type chair and four wheelchairs. The shorter hall with the higher numbered rooms had a large amount of equipment stored on the hall, lined up on one

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side of the hall that included four wheelchairs and two blood pressure rolling monitors. The equipment lined up along the length of both of these halls was observed to be an accident hazard for residents who ambulated on those halls.

Observation on 3/26/25 at 5:00PM revealed that the long hall with the lower numbered rooms had a large amount of equipment stored on the hall. Lined up on one side of the hall included a medication cart, three mechanical lifts, two walkers, two Broda type chairs, four wheelchairs and a standard chair. The shorter hall with the higher numbered rooms had a large amount of equipment stored on the hall. Lined up on one side of the hall that included a medication cart, three wheelchairs, two blood pressure rolling monitors and a cart with an ice cooler.

Observation on 3/27/25 at 2:45PM revealed that the long hall had equipment stored on the hall. Lined up on one side of the hall the length of the hall included four mechanical lifts, two walkers, one Broda type chairs and two wheelchairs. The shorter hall equipment stored on the hall, lined up on one side of the hall that included four wheelchairs, two blood pressure rolling monitors and two mechanical lifts.

During an interview on 3/28/25 at 9:17AM, the Director of Nursing (DON) indicated that she had been told that as long as all of the equipment was lined up on one side of the hall that was acceptable. She indicated that the facility did not have a storage area for the resident care equipment but indicated that maybe she could make a room for equipment storage. She further indicated that the equipment in the hall was, "an

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F 689	Continued From page 31 accident waiting to happen."	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that respiratory supplies were stored in a proper manner to prevent infections for 2 of 2 residents (R6 and R16) sampled for respiratory care in a total sample of 15 residents. Findings include: 1. R6's diagnosis in the electronic record on 3/26/25, included, but was not limited to hypertensive heart disease with heart failure. R6's 12/26/24 quarterly Minimum Data Set (MDS-a federally mandated assessment) recorded R6 had a Brief Interview for Mental Status (BIMS) score was 15, indicating intact cognition. The comprehensive care plan initiated on 5/17/23 recorded R6 had an altered respiratory status and difficulty breathing related to shortness of breath and chronic bronchitis. The care plan included an	F 695	Respiratory supplies for R6 and R16 were properly stored on 03/27/25 DON and ADMIN checked all other respiratory supplies to ensure proper storage. All residents who use respiratory supplies have the potential to be affected by this. R6 and R16 respiratory supplies were stored immediately when DON was notified on 03/27/25 All staff were educated on 04/24/25 on proper storage of respiratory equipment. Respiratory storage audit was conducted on 03/31/25 by DON 3 Audits X 4 weeks then 1 audit x 4 weeks or until substantial compliance is met. Audits will be reviewed during facilities monthly QAPI meeting for three months. Review of the audits will be completed by members of the QAPI committee to determine areas of improvement and revisions to maintain compliance.	03/27/25

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intervention dated 5/17/23 that instructed nurses to administer medications as ordered.

R6's electronic record documented an order dated 1/14/2025 for Albuterol Sulfate (a respiratory medication) 2.5 milligrams in a 3 milliliter solution to be given inhalation through a nebulizer (a small machine that turns liquid medication into a mist that can easily be inhaled) every 6 hours as needed.

During an observation on 3/24/25 at 5:42 PM, R6's nebulizer was stored in her room not covered, bagged or protected by a barrier on a tote that sat behind her, out of reach next to a pair of shoes. R6 indicated that she could not reach the nebulizer and that the nursing staff had placed the nebulizer on the tote.

During an observation on 3/26/25 at 1:02 PM, R6's nebulizer was stored in her room not covered, bagged or protected by a barrier on a tote that sat behind her, out of reach next to a pair of shoes.

During an observation and interview on 3/27/25 at 9:50 AM, Registered Nurse (RN2) observed R6's respiratory nebulizer on the tote next to a pair of shoes open to air and not bagged. RN2 indicated that the facility does not bag or cover respiratory equipment that is kept in a resident's room.

2. R16's diagnosis in the electronic record on 3/26/25, included, but was not limited to heart failure.

R16's 2/20/25 quarterly Minimum Data Set (MDS-a federally mandated assessment) recorded R16 had a Brief Interview for Mental

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F 695	Continued From page 33 Status (BIMS) score was 15, indicating intact cognition. The comprehensive care plan initiated on 7/5/23 recorded R16 had an altered respiratory status and difficulty breathing related to heart failure and the use of a BIPAP machine (a type of ventilator used to treat chronic conditions that affect breathing). The care plan did not document how the respiratory equipment would be stored and did not include the use of a mask for respiratory treatments. R16's electronic record documented an order dated 8/9/23 for BIPAP mask and tubing cleaning by hand washing in dish liquid detergent and warm water, then air dry. The order did not document how to store the equipment. The electronic record lacked an order for the respiratory treatment and mask. During an observation on 3/26/25 at 1:47 PM, R16's respiratory treatment mask remained stored in her room not covered, bagged or protected by a barrier on the table. R16's BIPAP mask sat on her walker tray not bagged or covered and with no barrier. R16 indicated that the nursing staff placed the BIPAP mask in that position. During an observation and interview on 3/27/25 at 10:19 AM, Registered Nurse (RN2) observed the storage of R16's BIPAP tubing disconnected and open on both ends on the bed and the mask on the bedside table, both with no barrier or covering. The respiratory mask remained on the table with no barrier and not bagged. RN2 indicated that respiratory equipment is stored in resident's rooms and is not bagged or covered.	F 695		

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F 695	Continued From page 34 During an interview on 3/28/25 at 9:14 AM, the Director of Nursing (DON) indicated that all respiratory tubing, masks and nebulizers should be bagged between use. She further indicated that she was made aware that this was a problem when the nurse told her that they had been interviewed regarding the storage of the equipment and that she was in the process of ensuring all respiratory equipment is now bagged and that nursing staff are educated on this process. The facility did not provide a policy to address the storage of respiratory nebulizers and masks.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		

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F 761	Continued From page 35 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, manufacturer guidelines, and interview, the facility failed to ensure medications used in the facility were stored in accordance with accepted professional principles. The facility failed to date an insulin pen when opened for 1 of 1 resident (R) observed (R21) during medication administration. Findings include: The facility policy titled Administering Medications revised April 2019, stated medications were administered in a safe and timely manner, and as prescribed. The Policy Interpretation and Implementation revealed in pertinent part "the expiration/beyond use date on the medication label was checked prior to administering and when opening a multi-dose container, the date opened was recorded on the container." The Novolog Flex Pen Manufacturer Package Insert revised August 2022, stated in pertinent part "the pen could be stored at room temperature for 28 days and after that, the pen would be thrown away even if it contained insulin." The Annual Minimum Data Set (MDS-federally mandated comprehensive assessment) for R21 dated 2/6/25, identified a Brief Interview of Mental Status (BIMS) score of 6, severe cognitive	F 761	Charge nurse immediately threw insulin pen away on discovering the issue for R21 insulin pen. Charge nurse opened new insult and dated to use. All residents who receive insulin have the potential to be affected by this. Medication label and date audit was conducted on 03/31/25 by DON 3 audits X 4 weeks then 1 audit X 4 weeks or until substantial compliance is met. All staff were educated by DON on 04/24/25 on proper medication label and dating. Audits will be reviewed during facilities monthly QAPI meeting for three months. Review of the audits will be completed by members of the QAPI committee to determine areas of improvement and revisions to maintain compliance.	03/31/25

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impairment. The MDS listed diagnoses of diabetes, hypertension, and Alzheimer's. The MDS recorded the resident received insulin injections daily in the last 7 days.

Review of R21's Treatment Administration Record (TAR) dated March 2025, included an order for Novolog injection per sliding scale four times a day for diabetes. If blood sugar 200-250 give 2 units, 251-300 give 4 units, 301-350 give 6 units, 351-400 give 8 units, and 401-450 give 10 units. Test blood sugar both midday and at bedtime and call if blood sugar over 401, start date 2/9/24.

During an observation on 3/26/25 at 12:02 PM, License Practical Nurse 1 (LPN1) checked R21's blood sugar with Registered Nurse 1 (RN1) observing. LPN1 obtained a blood sample, and the glucometer (monitor to check blood sugar) identified a blood sugar of 309 mg/dL. LPN1 proceeded to administer R21's Novolog insulin 6 units, as ordered. The Novolog insulin pen lacked a date when opened. LPN1 stated she had not opened the insulin pen and confirmed the insulin pen was not dated. LPN1 stated the insulin pens were to be dated when opened. RN1 stated they would figure out who and when the insulin pen was opened.

During a follow-up interview on 3/26/25 at 12:26 PM, LPN1 and RN1 stated they threw the Novolog pen away, opened a new one, and dated 3/26/25 due to being unable to determine when the pen was opened.

During an interview on 3/27/25 at 11:03 AM, the Director of Nursing (DON) stated she expected insulin pens and vials to be dated when opened.

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F 880	Continued From page 37	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165312	A. BUILDING _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FONDA SPECIALTY CARE	607 QUEEN STREET FONDA, IA 50540

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F 880	Continued From page 38 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have an effective water management plan to address the facility identified Legionella (a serious water born bacteria) risks. The deficient practice had the potential to affect all residents in the facility. The facility identified a census of 41 residents. Findings include:	F 880	Legionella Managment plan was revised on 04/14/25 by Administrator. Education was provided to Administrator by Regional Director of Facilities Management on 04/10/25. All residents had the potential to be affected by this. Emergency Disaster plan was revised to ensure correct procedures for legionella on 04/18/25. Audit conducted by Administrator on 04/24/25 weekly X4 weeks or until substantial compliance is met. Audits will be reviewed during facilities monthly QAPI meeting for three months. Review of the audits will be completed by members of the QAPI committee to determine areas of improvement and revisions to maintain compliance.	

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F 880	Continued From page 39 Review of the water management binder on 3/27/25 revealed the facility assessed and described the building water systems using a text and flow diagram. The diagram identified areas most at risk for opportunistic waterborne pathogens to grow and spread throughout the water system. The areas most at risk were identified by highlighter on the diagram and included the north and south boilers, north and south water heaters, water softener and mineral tanks, whirlpool tub, two shower heads and hoses, holding tank, ice machine and the kitchen hot water heater. The Legionella Water Management Program lacked measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in the building water systems that was based on the map water diagram, lacked testing protocols and acceptable ranges for control measures. During an interview on 3/27/25 at 4:38 PM, the Administrator indicated that the Water Management Program lacked documentation that the areas identified within the water system as being opportunistic for Legionella growth were monitored or tested and lacked any mitigation efforts by the facility.	F 880		