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	165460	A. BUILDING _____ B. WING _____	C 03/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAREN ACRES CARE CENTER	3605 ELM DRIVE URBANDALE, IA 50322

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F 000	INITIAL COMMENTS Correction Date: 03/05/2021 The Iowa Department of Inspections and Appeals (DIA) in accordance with the Medicare Conditions of Participation set forth in 42 CFR 483, Subpart B-C, conducted this Recertification survey and investigation of a facility reported incident and complaint. The facility was found to be NOT IN COMPLIANCE. Total residents: 29 Onsite dates: 02/25/2021 - 03/04/2021 During the survey, the following facility reported incidents and complaint were also reviewed: #89135 - I not substantiated #89136 - C not substantiated.	F 000	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the regulations established by state and federal law.	03/05/21
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, staff interview, and review of manufacturer's instructions, the facility failed to ensure the proper handling of a syringe and	F 658	Education was immediately provided to Staff D by ADON after she witnessed the handling of the syringe. Education was also provided related to the administration site for insulin. On 3/5/21, the DON also shadowed Staff D for morning and noon med passes to observe Staff D's profeciency in the skills mentioned above and Staff D was able to demonstrate proficiency and understanding. DON conducted interviews with the other charge	03/05/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pam Harned, MHA, LNHA — TITLE: Administrator — (X6) DATE: 3/26/2021

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.

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F 658	Continued From page 1 needle for 1 of 4 residents observed who received insulin during medication pass (Resident #18). The facility reported a census of 29 residents. Findings include: 1. During observation 03/01/21 at 12:12 PM, Staff D, Registered Nurse, removed a bottle of insulin from the medication cart and drew up 9 units of Humalog insulin into a syringe for Resident #18. Staff D held the syringe with the needle exposed in her hand as she walked from the medication cart through the dining room amongst residents seated at tables in the dining room. Staff D and wheeled Resident #18 in a wheelchair to the nursing manager's office, and continued to hold the syringe in her hand with the exposed needle pointed upward. The distance from the medication cart to the dining room table, where the resident was located, to the nurse manager's office was approximately 50 feet. Staff D stated she forgot to grab an alcohol swab, and walked approximately 50 feet back to the medication cart, and continued to hold the syringe with an exposed needle in her hand. Staff D obtained an alcohol swab from the medication cart, walked back to the nurse manager's office holding the syringe with the exposed needle in her hand. At 12:16 p.m., Staff D administered the injection to Resident #18, walked to the medication cart, and placed the used syringe into a sharps container on the medication cart. In an interview 03/03/21 at 01:05 p.m., Staff E, RN, reported the syringes used for injections at the facility had a walking mode and a safety mode. Staff E stated that after he drew medication into the syringe, he pulled the safety	F 658	nurses who appropriately described the expecations and best practices. DON will perform random audits of med pass/administration to continue to check for proficiency in skills. Any identified issues or concerns will be presented to the QA team.	

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F 658	Continued From page 2	F 658	Type text here	

cap up over the syringe, which he considered the walking mode. Staff E reported the safety cap in walking mode used to prevent inadvertent injection of the needle or medication into another person or himself as he walked to his destination and administered the injection. Staff E reported after he administered the injection, then he pulled the safety cap up and twisted the safety cap over the needle. Staff E stated he then disposed of the needle and syringe into a sharps container.

In an interview 03/04/21 at 11:45 a.m., the Assistant Director of Nursing (ADON) reported she saw Staff D when she walked through the dining room and brought Resident #18 to her office to administer an injection. The ADON acknowledged she saw Staff D carry the syringe with the needle exposed through the dining room and to her office. The ADON stated she expected the safety cap covered the needle to prevent the nurse and other residents from being stuck with the needle unexpectedly.

A facility policy for Medication Administration revealed all medications are administered safely and appropriately. Medications administered per professional standards for licensed nurses.

The Covidien Monoject Insulin Safety Syringe instructions for use revealed the following procedural steps:
a. Open the package
b. Fill the syringe with medication
c. Extend the safety shield forward until a positive stop felt and an audible snap heard. This will secure the safety shield for safe transportation to the patient site. Do not twist the safety shield or syringe.
d. To administer the injection, retract the safety

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F 658	Continued From page 3 shield until it snaps into the original position. e. Immediately following the injection, extend the shield forward fully until a click is heard. Lock the safety shield by twisting in either direction until a positive stop and audible snap heard. 2. During observation on 03/01/21 at 12:17 p.m., Staff D, prepared aspart insulin 6 units for Resident #13. At 12:20 p.m., Staff D administered aspart insulin to Resident #13's right arm 1 ½ inches above the resident's right elbow. In an interview 03/04/21 at 11:16 a.m., the ADON reported the subcutaneous insulin injection should have been administered into the resident's upper arm. A facility procedure titled Subcutaneous Injection revealed preferred sites of injection included the dorsolateral aspect of the arm three to five inches above the elbow.	F 658		
F 755 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(g). 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	F 755	ADON immediately provided education to Staff D regarding the expectation and best practice to immediately document narcotic administration in the narcotics log (not just the e-MAR) rather than at the end of the med pass. All other charge nurses were also provided education on the expected best practice. On 3/5/21, DON shadowed Staff D during medication administration and observed that Staff D was performing the expected best practice. DON will continue to provide random audits of narcotic administration. Any identified issues or concerns will be presented to the QA team.	03/05/21

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F 755	Continued From page 4 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 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 observation, staff interview, Controlled Drug Receipt Record/Disposition form, and facility policy review, the facility failed to sign out controlled substance medications in a reconciliation logbook when the controlled substances were removed from a locked box in the medication cart for 7 of 7 residents. The facility reported a census of 29 residents. Findings include: Observation of the medication cart on 03/02/21 at 01:46 p.m., with Assistant Director of Nursing (ADON) and upon surveyor request of a random	F 755		

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F 755	Continued From page 5 check of controlled substances revealed the following: Prior to opening the medication cart, the ADON requested Staff D, Registered Nurse (RN) who had responsibility of the medication cart for that day to stand by while the narcotic count was conducted. The ADON reported the nurse responsible for the medication cart and performed narcotic count at shift change. During review surveyor randomly selected resident's name and drug from the controlled substance record book. The ADON showed the medication card and the number of pills left in the medication card bubble pack. When the surveyor found a discrepancy in the count, Staff D stated she had just given the medication to the resident and had not had time to fill out the form. After Staff D filled out the controlled substance form on that resident, the surveyor and the ADON resumed the controlled substance count, and found another medication discrepancy. Staff D stated she had been busy that day. Surveyor asked if there were other narcotics or controlled substances that had not been signed out at that time, Staff D replied "yes". Staff D proceeded to go through the Controlled Substances book and sign out the additional medications she had dispensed and given to residents earlier in the day. The surveyor and ADON watched Staff D as she completed 7 Controlled Drug Receipt Record/Disposition forms for medications previously administered on 03/02/21. Interview on 03/02/21 at 02:24 p.m., the ADON	F 755		

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F 755	Continued From page 6 reported she expected staff to sign out narcotics/controlled substances, nursing staff were counting the narcotics at the change of shift, and staff was held accountable for ensuring the narcotic count was correct and those medications were accounted for before staff left the building. Interview on 03/04/21 at 11:55 a.m., the ADON reported the best practice was for the nurse to sign out narcotics whenever they took the medication out of the medication cart and dispensed the medication. The ADON reported a history of drug diversion at the facility a couple of years ago and Department of Inspections and Appeals (DIA) had investigated. At that time, the facility management tightened up their process for handling of controlled substances. The ADON reported they had no other policy except the Narcotic policy provided.	F 755		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14	F 809	ADON and Dietary Manager collaborated reagrding the logistics of evening snacks. Cook places refrigerated items in break room fridge. Room temperature items are placed at the nurse's station. CNAs are responsible for distributing/offering the snacks to all residents. Charge nurse will provide assurance that the CNAs complete this task. Staff educated on this process during shift change meetings on dates 3/2 and 3/3. DON to conduct follow up interviews with charge nurse and residents to ensure that the snack pass is occurring	03/05/21

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F 809	Continued From page 7 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: -- Based on observations, resident and staff interviews, and record review, the facility staff failed to offer all residents' a substantial evening snack causing more than a 14 hour lapse of time between the evening meal and breakfast for 5 of 5 residents. The facility reported a census of 29 at the time of the survey. Findings: Observation on 02/25/21 at 9:34 a.m. found employee breakroom refrigerator, empty of food and only a pitcher of juice present. Observation on 03/02/21 9:39 a.m. found a plastic tub with peanut butter and jelly sandwiches, dated and labeled in the employee breakroom. Staff A, Dietary Manager revealed that the evening cook made them for residents bedtime snack. She stated she did not know why the staff did not pass them out as the container was full and it appeared none of the sandwiches had been distributed. The residents could ask for a different snack if allergic to peanut butter or if	F 809	in the evening. Any identified issues or concerns will be presented to the QA team.	

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F 809	Continued From page 8	F 809		

they did not like the sandwich. Staff A did not know if the evening cook told the nursing staff the snack was in the employee refrigerator or not.

During an interview on 03/01/21 at 10:20 a.m. with Staff C, Dietary Aide (DA) revealed that she does not typically see food in the employee refrigerator so doubts the evening cooks are making snacks.

During an interview on 03/01/21 at 1:06 p.m. with Resident #2, he stated the facility does not have a snack cart and does not offer evening snacks, "It would be nice if they offered us something before bed, they never have while I have lived here."

During an interview on 03/01/21 at 1:06 p.m., with Resident #4, she stated the evening staff does not offer a bedtime snack, "It would be nice if they did."

During an interview on 03/03/21 at 8:55 a.m., Resident #1 revealed that she saw a snack cart in the evening of 03/02/21, and said, "It was so nice to have an option of a snack, I chose a cookie, that was the first time I have gotten a snack before bed."

During an interview on 03/03/21 at 8:57 a.m. with Resident #4, she revealed that she received a bedtime snack the night before, "That was the first time I have ever seen a snack cart, I got a half of a sandwich and enjoyed it."

During an interview on 03/03/21 at 8:58 a.m., Resident #2 revealed he received a snack off the snack cart the evening prior, "I received a piece of banana bread, it was nice."

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F 809	Continued From page 9 During an interview on 03/03/21 at 9:35 a.m., with Staff B, cook, revealed he usually will make a snack for residents in the evening and place in the employee refrigerator. He said he typically tells the charge nurse but does not know if they pass the food out to residents because his shift ends at 7 p.m. Staff B stated he thinks some of the staff knew about a bedtime snack but did not think they all knew about it. Record review of undated facility document titled, Nourishments, revealed: Objective: To offer a snack prepared by dietary Policy: To offer a snack daily to each resident as able Procedure: 1) Offer a variety of snacks on snack cart. 2) Items that need to be kept cold will be placed on ice. 3) Specialized snacks will be labeled. 4) Spoons and napkins will be provided as needed. 5) Dietary staff will deliver snacks to designated areas. 6) Nursing staff will offer snacks to residents. 7) Nursing staff to return unused items to dietary department after snack pass. Record review of undated facility document titled, Dietary Services, revealed, Objective: In order to be physically stable, a therapeutic diet should be provided and consumed on a daily basis. (Start with #4) At least three meals or their equivalent will be served daily during regular hours. There will not be more than a 14-hour span between meals.	F 809		