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	165372	A. BUILDING _____ B. WING _____	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST RETIREMENT COMMUNITY	2104 12TH STREET HARLAN, IA 51537

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F 000	INITIAL COMMENTS Correction Date: 9/30/22 The following deficiencies resulted from the annual recertification survey with intakes #104550-C and 103778-C conducted from 8/22/22 - 8/25/22. Complaint #103778 was substantiated. Complaint #104550 was not substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 689 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record reviews, and facility policy review, the facility failed to utilize interventions to help prevent falls for one of two residents (Resident #36) reviewed for falls in a total sample of 12 residents. The facility reported a census of 38 residents. Findings include: The facility's Certified Nursing Assistant (CNA) Job Description dated 9/22/15, indicated the primary purpose of this position is to provide quality beside care and assistance in all activities	F 689	See Attached POC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy J Maesar	Administrator	9/22/2022

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 689	Continued From page 1 of daily living for the residents, in accordance with the resident's assessments and care plan. The Section labeled Duties and Responsibilities indicated that the CNA have knowledge of the individualized care plan for residents and provide support to the resident according to the care plan. Resident #36's electronic medical record (EMR) under his "Profile" tab revealed Resident #36 readmitted to the facility on 3/1/18. Resident #36's Medical Diagnosis (Med Diag) tab in his EMR included diagnoses of spastic hemiplegia (paralysis) affecting the left non-dominant side. Resident #36's Minimum Data Set (MDS) assessment dated 5/18/22 identified a Brief Interview Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Resident #35 required the extensive assistance of two persons with transfers. The Care Plan indicated that Resident #36 had a risk for falls due to poor balance from left sided hemiplegia. On 3/5/22 during a transfer, staff lowered Resident #36 to the floor revised 3/31/22. With only one assist, he got to the floor on 7/27/22. Resident #36's current Fall Risk assessment score showed a score of 7, indicating at risk as of 8/7/22. Created on: 3/12/18 Revision on: 8/16/22...3/13/22 staff educated on the need for two to transfer and to have the wheelchair brakes locked. Date Initiated: 5/24/22. 3/5/22 staff educated on needing two for transfers. Date Initiated: 5/24/22...7/27/22 staff educated to use two staff for transfers Date Initiated: 8/1/22. 7/24/21 educated staff to ask for help when transferring. Date Initiated: 8/1/21.	F 689	See Attached POC	

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F 689	Continued From page 2 The Visual/Bedside Kardex Report reviewed on 8/22/22 documented that Resident #36 required two person extensive assistance with a gait belt for transfers. Resident #36 required extensive assistance of two persons with a gait belt for toilet use. The N Adv-Post Fall Evaluation dated 7/27/22 at 8:01 AM labeled as Late Entry recorded the following fall as witnessed. Who witnessed fall: CNA2 lowered Resident #46 to the floor while in the bathroom. At the time of fall Resident #36 received assistance to the toilet by one aide. The cause of the fall is listed as evident due to only one aide present. Resident #36's Short Term Post Falls Care Plan instructed the following ... 3/31/22 at 7:30 PM: Number of staff for transfers - 2. Always lock the wheelchair during transfers in and out. 7/27/22 at 8:01 AM: Always use two assist to transfer. On 8/23/22 at 1:44 PM Licensed Practical Nurse (LPN) 1 explained the staff expected CNA to follow Resident #36's Care Plan and implement interventions of two person assist for Resident #36's transfers. LPN 1 confirmed Resident #36 suffered three falls (from 3/22 to 7/22) because CNA staff did not implement Resident #36's care plan interventions to provide two persons assistance with his transfers. LPN 1 confirmed that she educated all three of the CNA staff members involved, to refer to Resident #36's Care Plan and implement the interventions to prevent falls with two-person assistance for transfers. LPN 1 confirmed that the CNA staff	F 689	See Attached POC	

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F 689	Continued From page 3 accessed Resident #36's Care Plans on their iPad. LPN 1 confirmed that all three falls happened due to staff not implementing Resident #36's Care Plan interventions. On 8/23/22 at 2:40 PM the Director of Nursing (DON) confirmed that she expected the facility's staff to follow Resident #36's Care Plan including implementing interventions for his transfers to use two-person assistance. The DON acknowledged that Resident #36 suffered three fall incidents from March to July 2022. The DON confirmed the facility's staff did not implement Resident #36's Care Plan interventions to use two persons to assist him with his transfers and only provided one person assistance for all three of Resident #36's fall incidences. The DON verified the staff members involved with Resident #36's falls received education. The DON confirmed that Resident #36 suffered no injuries with each of the three falls. On 8/24/22 at 9:51 AM CNA 4 confirmed that Resident #36's Care Plan interventions included that he required two person assistance with transfers and toilet use. CNA 4 acknowledged that Resident #36 did not walk and had paralysis on his left side (arm and leg). CNA 4 confirmed that the facility provided CNA 4 and the rest of the staff an iPad that contained Resident #36's Care Plan interventions, including that he required two person assistance for transferring and toilet use. CNA 4 confirmed the facility educated her on following the residents' Care Plan interventions. On 8/25/22 at 9:20 AM Registered Nurse (RN) 1 that confirmed CNA 2 attempted to transfer Resident #36 by herself on 7/27/22, causing Resident #36 to suffer a fall. RN 1 confirmed	F 689	See Attached POC	

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F 689	Continued From page 4 Resident #36's Care Plan interventions directed staff to use two persons when assisting with transfers. RN 1 confirmed Resident #36 suffered three falls from 3/22 to 7/22. RN 1 confirmed that all three of Resident #36's falls resulted from the CNA staff members attempting to transfer Resident #36 without assistance of two people and that they did not follow his Care Plan interventions. RN 1 verified that after each of Resident #36's fall incidences, the nursing staff educated the CNA staff of the importance of following Resident #36's Care Plan interventions. RN 1 confirmed that although no injuries occurred, Resident #36 had a potential for harm from his fall incidents because the CNA staff did not follow his Care Plan interventions.	F 689	See Attached POC	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		

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F 757	Continued From page 5 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, Physician Assistant (PA) interview, staff interviews, clinical record reviews, and facility policy review, the facility failed to ensure the appropriate use of antibiotic therapy for one (Resident #34) of five residents reviewed for unnecessary medications in a total sample of 12 residents. The facility reported a census of 38 residents. Findings include: The "Urinary Tract Infections/Bacteriuria - Clinical Protocol," revised 4/18, directed that the new onset of nonspecific or general symptoms alone (change in mental status, decline in appetite, etc. [and so forth]) is not enough to diagnose a urinary tract infection (UTI). Urine odor, color, and clarity also are not adequate to indicate bacteriuria (bacteria in the urine) or a UTI." Resident #34's Minimum Data Set (MDS) assessment dated 8/3/22 documented an admission date of 9/25/15. The MDS included diagnoses of UTI, depression, and anxiety. The MDS identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #34 required extensive assistance of two persons for toilet use. The MDS indicated Resident #34 had frequent incontinence of bowel and bladder. Review of Resident #34's Care Plan revised 8/12/22 indicated that Resident #34 recently had a UTI. The Care Plan included an intervention to	F 757	See Attached POC	

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F 757	Continued From page 6 observe for s/s [signs and symptoms] of a UTI, i.e. [such as] increased confusion, discolored urine, back pain, foul odor. The Behavior Note dated 7/21/22 at 12:18 PM identified the nurse continued to chart behaviors d/t [due to] a decrease in Prozac (antidepressant medication) and discontinuation of Clonazepam (antianxiety medication). Resident #34 refused to go to the dining room for breakfast but propelled herself in the wheelchair in the hallway wanting to know why she did not get fed in days. The nurse told her the staff had offered but she refused. The nurse told her that she needed to get her weight, Resident #32 declared that they did not in a very stern voice and grabbed her wheelchair wheels and started to propel back to her room. The nurse explained that she sat only a few feet away from the scale and then she agreed to be weighed. Resident #34 requested to go back to her room. The staff assisted her to her room and approximately a half hour later, she propelled herself to the dining room again wanting to get weighed. Resident #34 ate a couple bites of cheerios with milk and took a sip of water. Resident #34 refused to go to the beauty shop and to the dining room for lunch. She denied wanting a tray brought to her room. Refuses her morning medications but she did take her noon medications with only a sip of water. The staff offered her fluids multiple times throughout the shifts but ignored them or told them no. The nurse explained that they needed a UA (urinary analysis) on her to send to the lab [laboratory] but Resident #34 closes her eyes and no longer talks to the nurse. Resident #34's July 2022 "Medication Administration Record (MAR)," located in the	F 757	See Attached POC	

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F 757	Continued From page 7 EMR under the "Orders" tab, identified an order dated 7/22/22 for Cipro (an antibiotic medication) Tablet 250 MG [milligrams] (Ciprofloxacin HCl) to give one tablet by mouth two times a day for a UTI for 10 administrations. Documentation indicated that Resident #34 received all ten doses of her antibiotic. Resident #34's Urinary Culture (UC), Final Result dated 7/21/22 recorded a result of colony count less than 10,000. No workup. On 8/22/22 at 11:00 AM, observed Resident #34 in bed with her face mask positioned over her eyes. Resident #34 did not respond to the surveyor's greeting. On 8/23/22 at 10:10 AM, when asked why Resident #34 used an antibiotic recently, Licensed Practical Nurse (LPN)1 stated that Resident #34 had a change in her mental status that led them to suspect a UTI. Upon further questioning about what criteria or tool they used to determined that Resident #34 needed antibiotics, LPN1 explained that if they suspected a UTI, they used an algorithm to determine how to proceed and based on that, the physician would be called. LPN1 provided a copy of the algorithm. LPN1 added that the physician could order a urinary analysis and depending on the results, he could order monitoring, to push fluids, or order an antibiotic. When questioned what bacteria Resident #34 got treated for in July 2022, LPN1 she stated that she did not know. She then checked the laboratory report and confirmed that urinary culture contained no bacteria. LPN1 said that even though the culture results did not identify an organism, the physician would know what antibiotic to use as the nursing home staff	F 757	See Attached POC	

See Attached POC

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F 757	Continued From page 8 don't necessarily need to know, as they follow the doctor's orders. Review of the Algorithm diagram, titled "Management Algorithm for Suspected UTI in LTCF (Long Term Care Facilities)" provided by LPN1, revealed no explanation of "Met Criteria" to determine what constituted a UTI based on the UA and UC. On 8/24/22 at 11:10 AM, when asked about what organism Resident #34 got treated for in July 2022, the Infection Preventionist (IP), reported that the UC did not identify an organism as the colony count showed less than 10,000 organisms, indicating no need for further workup. When questioned about what signs and symptoms Resident #34 had and what criteria they used for UTIs, she stated Resident #34 had a change in mental status and no other real UTI signs and symptoms. The IP explained that the physician determined the criteria. Upon questioning the IP about their UTI policy which included that a mental change alone didn ' t qualify to diagnose a UTI. The IP stated she relied on the doctor to make the judgment. When asked the importance for staff to know the organism being treated in case the resident had a superbug such as VRE (Vancomycin-resistant Enterococci) or CRE (Carbapenem-resistant Enterobacteriaceae), and Resident #34 needed to be under TBP (Transmission Based Precautions), she replied that UC did not identify organisms due to too few bacteria. She stated the UA revealed a moderate amount of bacteria and a trace amount of blood present but not enough to treat. The IP asked if the facility had an antibiotic stewardship program and she said "yes." When asked if the physician got educated	F 757	See Attached POC	

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F 757	Continued From page 9 on their antibiotic stewardship program, she said that she never said anything to the physician because it wouldn't have made a difference; as the physician would continue to prescribe it [antibiotic medication] anyway. When questioned if Resident #34 ' s UA had a C&S (culture and sensitivity) done, she reiterated "that Resident #34 did not have any bug to treat because the lab had less than 10,000. During a telephone interview on 8/25/22 at 2:42 PM, the Physician Assistant (PA) confirmed that she prescribed the antibiotic, Cipro, for Resident #34. She explained that she prescribed the antibiotic to keep Resident #34 from becoming septic due to urocystitis [inflammation of the urinary bladder]. When asked if she knew of the facility's antibiotic stewardship program, she stated "yes," but referenced medical literature that justified her decision. However, she confirmed the negative culture with moderate amounts of bacteria present in the UA. She confirmed no organism grew from the UC. When asked what organism she treated if nothing grew in the UC, she said that UC did not find any but she treated suspected E.coli (Escherichia coli). She confirmed Resident #34 received the full amount of antibiotic treatment, Cipro	F 757	See Attached POC	
F 760 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 observations, staff interviews, clinical record reviews, and facility policy review, the	F 760		

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F 760	Continued From page 10 facility failed to follow the physician's order to administer insulin with the lunch meal for one (Resident #30) of seven residents observed for medication administration. The facility's deficient practice increased Resident #30's risk of an adverse drug reaction of hypoglycemia (low blood sugar). The facility reported a census of 38 residents. Findings include: The Adverse Consequences and Medication Errors policy revised in 4/21, defined a medication error as the preparation or administration of drugs or biological medicine which is not in accordance with physician's orders, manufacturer specifications, accepted professional standards, and principles of the professional(s) providing services. Resident #30's Order Details documented an order dated 1/18/16 for NovoLog solution (Insulin Aspart) to inject 10 units subcutaneously with meals related to type two diabetes mellitus without complications. A email reply dated 8/25/22 from the Pharmacist to the Director of Nursing (DON) identified that the DON asked the Pharmacist how fast the Novolog N pen insulin starts working after injection. The Pharmacist replied that per the drug reference onset is five to 15 minutes. The Novolog (insulin aspart injection 100 units/milliliters (ml) insert revised 10/21 included a section labeled Patient Information indicated that Novolog starts to act fast. A person should eat a meal within five to ten minutes after they take their dose of Novolog. The insert added to take	F 760	See Attached POC	

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F 760	Continued From page 11 Novolog exactly as the healthcare provider directs. The Instructions for Use: Novolog Flexpen dated 11/21 directed to give an airshot before each injection. The directions indicated the following Turn the dose selector to 2 units Hold the Novolog Flexpen with the needle pointing up, tap the cartridge gently with a finger a few times to make any air bubbles collect at the top of the cartridge. With the needle continuing to point up, press the button all the way until the selector returns to zero. During an observation on 8/23/22 at 11:27 AM Licensed Practical Nurse (LPN) 2 prepared medication for Resident #30 in the medication room for the southall medication cart, revealed: 1. Novolog R (Regular) per sliding scale 6 units injected for a blood sugar of 251 - 4 times a day with an expiration date of 4/30/22 with Registered Nurse (RN) 2 for verification. 2. Novolog N inject 10 units three times a day with meals with an expiration date of 7/31/23. LPN 2 set the insulin pen selector to 10 units. LPN 2 did not perform the airshot before setting the insulin pen. During an observation on 8/23/22 at 11:43 AM, LPN 2 entered Resident #30's room. Resident #30 sat in her wheelchair. LPN 2 administered Resident #30's two doses of insulin in her abdomen. Resident #30 did not have her lunch meal in her room. During an interview on 8/23/22 at 11:51 AM LPN 2 confirmed Resident #30 was not eating and had not been served her lunch meal at the time of the	F 760	See Attached POC	

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F 760	Continued From page 12	F 760	See Attached POC	

insulin administration. LPN 2 verified Resident #30's "MAR" physician orders included administering Novolog N insulin with meals which LPN2 verified that she did not follow.

During an interview on 8/24/22 at 4:38 PM, the Cook confirmed Resident #30's lunch meal did not leave the kitchen for delivery to Resident #30's room until 12:30 PM on 8/23/22, approximately 47 minutes after LPN 2 gave Resident #30 her insulins.

An interview conducted on 8/25/22 at 9:41 AM, Registered Nurse (RN) 1 confirmed that the nursing staff should follow the physician's orders with the administration of an insulin dose (with meals), otherwise the resident may become hypoglycemic. RN 1 confirmed that Novolog N insulin starts working 15 minutes after injection to decrease a resident's blood sugar.

An interview conducted on 8/23/22 at 2:21 PM the Director of Nursing (DON) confirmed that she expected the facility's staff to follow physician's orders. The DON confirmed the importance for the staff to follow the physician's orders for the resident's health benefit. The DON confirmed the importance for the facility's staff to follow manufacturer's recommendations for medications (including administering). The DON verified that not following the physician order of administering insulin with Resident #30's meal constituted a medication error.

A brief interview conducted on 8/25/22 at 10:54 AM the DON acknowledged that fast acting insulin starts working within 5-10 minutes after injection. DON reconfirmed her expectation for the facility's nursing staff to follow the physician's

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	165372	A. BUILDING _____ B. WING _____	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST RETIREMENT COMMUNITY	2104 12TH STREET HARLAN, IA 51537

(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
F 760	Continued From page 13 order for resident's medication administration of insulin with a resident's meal.	F 760		
F 761 SS=E	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 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 observations, staff interviews, clinical review records, and facility policy review, the facility failed to store residents' medications in a safe and secured manner in one of one medication storage room and one of two medication carts. Specifically, the facility did not	F 761	See Attached POC	

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F 761	Continued From page 14 consistently monitor the medication refrigerator temperature (containing vaccines), lock the medication refrigerator, or permanently affix (to the interior of the refrigerator) two locked containers (containing controlled substances). One of two medication carts contained used and discontinued controlled substances (not destroyed) for two residents (Residents #90 and #6) with the residents' current medications. The facility's deficient practice created potential for residents' controlled substances to be diverted and residents' vaccines to lose potency. The facility reported a census of 38 residents. Findings include: Review of facility-provided policy, revised 4/19, titled "Storage of Medications" directed the facility to store all drugs and biologicals in a safe, secure, and orderly manner. . . . Drugs and biologicals . . . are stored under proper temperature . . . Discontinued . . . drugs are returned to the dispensing pharmacy or destroyed . . . Compartments including but not limited to . . . refrigerator . . . are locked when not in use . . . Schedule II-V controlled mediations are stored in separately locked, permanently affixed compartments . . . " Review of facility-provided policy, revised 3/20, titled "DISPOSITION OF MEDICATION" instructed that discontinued medications by the physician or expired will be destroyed . . . A registered nurse and either another nurse or pharmacist can destroy the medication . . . Patches are disposed of in a RX (prescription) Destroyer . . . " Review of the un-dated facility-provided policy	F 761	See Attached POC	

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F 761	Continued From page 15 titled "Policy and Procedure for Vaccine Storage" directed to monitor the temperature two times a day and record on a flow sheet. Review of facility-provided document titled "August 2022 VACCINE TEMPERATURE LOG" lacked documentation of temperatures that indicated the facility did not monitor the medication refrigerator temperature (vaccine) consistently for the following dates: 8/9/22 morning (AM), 8/21/22 night (PM), 8/22/22 AM and PM. During a brief interview and observation on 8/24/22 at 10:47 AM, the Clinical Manager Registered Nurse (CM) verified the facility's refrigerator log had missing entries on 8/9/22, 8/21/22, and 8/22/22 for the Bio refrigerator containing the following vaccines: 1. Two unopened Influenza vaccine boxes with 0.5 ml multi dose vials with an expiration date of 6/30/23. 2. Five unopened Influenza vaccine adjuvanted boxes. Each box contained ten 0.5 ml single dose filled syringes with an expiration date of 4/14/23. During the same observation and interview, the CM verified the facility's un-locked medication refrigerator in the medication room contained: 1. One clear locked box (not permanently affixed to the interior of the unlocked refrigerator) in the locked medication storage room with one unopened 30 ml bottle of Lorazepam (anti-anxiety Schedule IV controlled substance) oral 2 mg/ml concentrate. 2. One clear locked box (not permanently affixed to the interior of the unlocked refrigerator) in the locked medication storage room with two	F 761	See Attached POC	

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F 761	Continued From page 16 unopened vials of Ativan (antianxiety Schedule IV controlled substance) 1 ml vial of 2 mg/ml. During an observation on 8/24/22 at 11:28 AM Licensed Practical Nurse (LPN) 2 of the south hall medication cart in the medication room, LPN 2 verified the locked narcotic box contained: 1. One clear rectangular bowl with a lid that contained residents' used folded controlled substance patches (greater than ten) with paper taped on the top that read discontinued meds (medications) with the residents' current controlled substances. LPN 2 verified they stored the residents' used fentanyl patches (a potent opioid Schedule II controlled substance) in the narcotic locked box with the residents' current medications. 2. Resident #90's hydrocodone [Schedule II controlled substance] tablets medication card had 23 tablets remaining (in a clear bag with red writing that read high alert). LPN 2 verified the physician discontinued Resident #90's hydrocodone tablets. The hydrocodone tablets did not get destroyed but continued to be stored with other facility residents' current medications in the narcotic locked box on the medication cart. During an observation of the second locked narcotic box with LPN 2 of the south hall medication cart revealed: 3. Resident #90's opened box of Fentanyl 12 microgram (mcg) patches had three remaining patches with an expiration date of 12/23 in a clear bag with "High Alert" written in red. LPN 2 verified the remaining count of three patches on the medication cart's narcotic logbook and had a handwritten note that read "discontinued 8/17/22."	F 761	See Attached POC	

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F 761	Continued From page 17 4. Resident #6's opened 30 ml bottle of liquid Ativan with an expiration date of 3/24. LPN 2 confirmed Resident #6 had expired (passed away). LPN 2 verified Resident #6's Ativan count had 17.5 ml remaining on the medication cart narcotic logbook with a handwritten note "expired 8/19/22." 5. Resident #6's opened bottle of Morphine sulfate oral solution 20 mg/ml with an expiration date of 1/24. LPN 2 verified Resident #6's Morphine on the narcotic logbook had 27 ml remaining with a handwritten note of "expired 8/19/22." LPN 2 verified the above discontinued medications did not get destroyed and continued to be stored with the residents' current medication. During an interview on 8/24/22 at 2:09 PM, the Director of Nursing (DON) verified the medication room refrigerator log had missing entries, indicating the task (monitoring temperature) did not get performed. The DON confirmed that she expected the staff to complete entries for the refrigerator temperature log. The DON confirmed the facility's policy about the medication refrigerator directed that it should be locked and the controlled substance container should be affixed to the interior of the refrigerator. The DON stated she and the Assistant Director of Nursing (ADON) were responsible for destroying controlled substances when they got orders to discontinue the medications or the medications expired. The DON confirmed she knew the facility stored the discontinued and expired medication with the residents' current medications in the locked narcotic box. The DON explained that the storage of the residents' discontinued or expired controlled medications with the current	F 761	See Attached POC	

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F 761	Continued From page 18 medications was safe because they were placed in a red bag used for the discontinued and expired medications. The DON confirmed the storage of the residents' used controlled substance/narcotic patches in the locked narcotic box in a bowl. The DON reported the ADON destroyed them weekly. The DON confirmed that keeping residents' used narcotic patches in a container in the narcotic box on the medication cart posed a risk for drug diversion to occur. The DON confirmed Resident #6 expired at the facility on 8/19/22 and she expected their controlled substance medications to be destroyed as soon as possible.	F 761	See Attached POC	

Elm Crest Retirement Community
License #830051, Provider/Supplier/CLIA #165372
Harlan, Iowa 51537

Plan of Correction
Preparation of the Plan of Correction does not constitute admission or agreement by the provider of the truths of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. Submission of the plan of correction shall not be construed as a waiver of this provider's right to contest any and all deficiencies, nor is such submission an admission that the facts are as alleged, or that any regulatory violation occurred.

The following is to be considered our Credible Allegation of Compliance.

F689 Free of Accidents Hazards/Supervision/Devices

Correct deficiency to individual:
Resident #36 has been assessed with no negative outcomes observed

Protect res. in similar situation:
All nursing staff were educated to follow the care plans for their residents and to use the proper lifting and/or transferring for those residents. The Care Plans and especially the lifting/transferring of the residents is for safety of both the residents and the staff and based on the nursing and therapy's assessment of the resident. All residents currently in facility have been assessed for the proper type of transfer and lifting to be used.

Measures/system prevent reoccur:
Nursing staff were and will be educated on the need for individually addressing each of the resident's ability to be lifted and/or transferred based on their Care Plan, designed by Inter-Disciplinary Team. This education will be conducted at Shift Huddles, Team Times 3X/week and at the next two All Staffs, 9/13/22 and 10/11/22.

Monitor permanent solution:
Audits will be conducted 3times/weekly for the next four weeks then weekly for the next eight weeks by the DON/Designee regarding the staff following resident's Care Plan during transfers and assessed for following the proper transfer techniques used.
Results of audits will be taken to the monthly QAPI meeting and evaluated for compliance for next 3 monthly meetings.

Date of Completion: 9/30/22

F757 Drug Regimen is Free from Unnecessary Drugs

Correct deficiency to individual:
Resident #34 has had their antibiotics reviewed and resident was assessed with result of no negative outcome.

Protect res. in similar situation:
All residents who were on antibiotics were reviewed and all had positive lab results for their use based on the McGeer's and Loeb's Criteria. No other residents were on antibiotics at this time. Nurses were educated on the proper use and stewardship of antibiotics for the residents and why this is needed.

Measures/system prevent reoccur:
Re-education was started with all nurses on antibiotic stewardship and the need to inform physicians of our stewardship program when antibiotics are prescribed. They were also educated on current infection screening tools used by nursing staff to identify infections and revised the process for infection screening and provider notification of infection symptoms. These new tools are based on both the McGeer's Criteria and Loeb's Criteria.
1.The IP nurse developed a new infection screening evaluation for nurses to fill out and fax to the medical provider when a resident has a suspected infection.
2. The IP nurse also developed an antibiotic timeout SBAR that will be sent to the doctor 48-72 hours after that start of any antibiotic.
Staff will be educated regarding this new program at Shift Huddles, Team Times 3X/week and at the next two All Staffs on 9/13/22 and 10/11/22.

Monitor permanent solution:
Infection Control/Designee will conduct audits on all new orders for antibiotics and their follow up with the physician for the next twelve weeks. Results of audits will be taken to the monthly QAPI meeting and evaluated for compliance for next 3 monthly meetings.

Date of Completion: 9/30/2022

F760 Residents are free from Significant Med Errors

Correct deficiency to individual:
Upon learning that the insulin being administered to resident #30 by LPN #2 was given before the meal instead of with the meal, LPN #2 gave resident a bowl of cottage cheese to prevent an adverse drug reaction of hypoglycemia from occurring. Resident was monitored for s/s of hypoglycemia until meal was given. No adverse reaction happened. Resident #30 was assessed and continues to do fine with no negative outcomes.

Upon learning that LPN #2 administered resident #30 her Novolog Flexpen insulin without first priming the insulin pen, nurse was properly educated on the need and proper technique to do this.

Protect res. in similar situation:
Pharmacy consultant was made aware of this occurring and reviewed proper administration instructions of the Novolog insulin. All residents receiving insulin have had their orders reviewed to see the specifications of when the insulin needs to be given in regards to meals. Education was provided to nursing staff on 9/19/22 on following doctor's orders and medication instructions when giving insulin, all future orders will be asked to clarify and if possible to say "to be taken with food". If order specifies "with meals", Nursing staff should be giving residents' insulin right before meal is given. They should be taking resident to area outside of dining room and giving the injection right before meal is served. If resident is eating in their room, nurse should be coordinating the administration of insulin with when the resident will be served their meal.
All nursing staff were instructed on the need to prime the insulin prior to administering the medication. Pharmacy consultant was notified of this occurring. On 9/19/22 nursing staff was also given education on proper administration of insulin with insulin pen. Staff development nurse had each nurse demonstrate properly priming an insulin pen with a "dummy pen" supplied by Pharmerica.

Measures/system prevent reoccur:
Education was provided to nursing staff on 9/19/22 on following doctor's orders and medication instructions when giving insulin and also given education on proper administration of insulin with insulin pen. Staff will be educated regarding the proper administration of insulin and following the physician's orders at Shift Huddles, Team Times 3X/week and at the next two All Staffs on 9/13/22 and 10/11/22.

Monitor permanent solution:
Staff Development Nurse /Designee will conduct audits on physicians' orders for insulin and proper priming technique 3X/week for four weeks, 2x/week for the next four weeks and 1X/week for an additional four weeks. Results of audits will be taken to the monthly QAPI meeting and evaluated for compliance for next 3 monthly meetings.

Date of Completion: 9/30/2022

F761 Label/Store Drugs and Biologicals

Correct deficiency to individual:
No residents were immediately affected

Protect res. in similar situation:
A new lock with key was attached to the refrigerator in question in the med room the next day. The lock is a separate key from the med room door and meets the requirements of the regulation and our policy.
Upon learning that discontinued controlled substances could not be stored with controlled substances still being used, a new process for storing these medications was created in order to keep them in a separate locked bin in the medication cart until they could be destroyed.
Upon learning that nursing staff were not consistently monitoring the temperature of the medication refrigerator, nursing staff were educated on the importance of doing this according to the current protocol of twice a day.

Measures/system prevent reoccur:
The Clinical Manager/ designee will monitor this med room refrigerator with new lock to insure it is locked and secure in the locked med room.
This red bag is placed into a locked bin inside the west hall medication cart. This bin is labeled that it is for discontinued medications only. The medication kept in this bin will still be counted each shift during the narcotics count until it is destroyed. When a nurse places a discontinued medication into this bin she will be alerting DON or Clinical Manager that a medication is needing destroyed so it can be done as soon as possible.
Medications and vaccines being kept in this refrigerator must be kept at proper temperature to prevent them from losing potency.
Nursing staff were educated on all three areas for the plan of correction on F761 on 9/ 19/22 and signed off on receiving this education.

Monitor permanent solution:
Clinical Manager/designee will perform Quality audits for all three areas of this tag three times per week for four weeks and twice/week for the next 4 weeks and once/week for another four weeks. Results of audits will be taken to the monthly QAPI meeting and evaluated for compliance for next 3 monthly meetings.

Date of Completion: 9/30/2022

Timothy J Nauslar
Administrator
Elm Crest Retirement Community
9/22/2022