STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165621	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens of Cedar Rapids	5710 Dean Road SW Cedar Rapids, IA 52404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on clinical record review, staff interviews, observations, and facility policy review the facility failed to prevent drug diversion for 3 of 3 resident's controlled/narcotic medications (Resident#89, #90, #92). The facility reported a census of 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #89 dated 7/18/24, listed diagnoses of non-Alzheimer's dementia, Parkinson's disease, and seizure disorder. The Brief Interview for Mental Status (BIMS) reflected a score of 1, severe cognitive impairment. The Care Plan for R#89 dated 4/26/24, directed staff to administer medications as ordered. Monitor and record effectiveness. Report any adverse side effects. The Controlled Substance Count & Usage Record for R#89 dated 9/13/24 at 2:00 PM reflected 24 milliliters (ml) of Morphine remained at the shift change cosigned by Staff I, Licensed Practical Nurse (LPN) and Staff A, Registered Nurse (RN). The next entry on the document dated 9/13/24 at 10 PM, reflected 22 ml remained. The record failed to reflect 2 ml of the Morphine being administered. The document revealed a note on the left side of the form count corrected The document failed to give an explanation of what happened to the 2 ml of Morphine. The Medication Administration Record (MAR) dated 9/13/2024, listed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 5 mg by mouth every 4 hours as needed (PRN) for Pain 0.25 ml or 5 mg every 4 hours as needed for pain. The MAR lacked a dose signed out/administered. 2. The MDS for Resident #90 dated 8/8/24, listed diagnoses of non-Alzheimer's dementia, diabetes mellitus, and heart failure. The MDS revealed a BIMS score of 00, that indicated sever cognitive impairments. The Care Plan for Resident #90 dated 6/24/24, directed staff to administer medications as ordered. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Controlled Substance Count & Usage Record for R#90 dated 9/13/24 at 2 PM, listed 8.75 ml of morphine remained. The record reflected Staff A, RN administered two 0.25 ml doses of the Morphine to Resident #90. One 0.25 ml dose at 2:57 PM and one 0.25 ml dose at 8:40 PM. The count at that time reflected 8.25 ml. At 10 PM the end of the shift count (CT) reflected 8.25 ml. The next line on the form revealed count correction 6 ml morphine remained. The document failed to explain why the count failed to include the location of the missing 2.25 ml. The MAR dated 9/2024, directed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 0.25 ml by mouth three times a day for pain. The MAR also listed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 0. 25 ml by mouth every 2 hours as needed for Pain or dyspnea, none signed out PRN on 9/13/24. 3. The MDS for Resident #92 dated 9/12/24, listed diagnoses of lung cancer, non-Alzheimer's dementia, arthritis, and diabetes mellitus. Resident #92's MDS reflected her BIMS score of 15, intact cognition. The Care Plan for R#92 dated 9/19/24, directed staff to use pain management as appropriate. Monitor/document side effects and effectiveness. The MAR dated 9/19/24, directed Ativan Solution 2 MG/ML (lorazepam). Give 0.5 mg sublingually every 2 hours for terminal pass. The Controlled Substance Count & Usage Record for R#92 dated 9/19/24 at 12:35 PM showed 29.5 ml of morphine solution, staff gave 0.5 ml that left 29 ml. The next time on the record reflected 2 PM, and 28.75 ml remained. The count failed to reflect 0.25 ml of the morphine solution. The Controlled Substance Count & Usage Record for R#92 dated 9/19/24 at 5:45 PM showed 29.5 remained of the Ativan Solution. After 0.5 ml administered the count reflected the amount that remained as 27 ml. Review of the Daily Assignment sheet dated 9/13/24, listed Staff I, Licensed Practical Nurse (LPN), worked 6 to 2 PM, Staff A, Registered Nurse (RN) worked 2 PM to 10 PM and Staff D, RN worked the 10 PM to 6 AM shift. The medication signed out 4 times on the shift. Review of the Daily Assignment sheet dated 9/19/24, listed Staff H, RN worked the 6 AM to 2 PM shift, Staff, A worked the 2 PM to 10 PM shift, and Staff D, LPN worked 10 PM to 6 AM shift. On 1/9/24 at 9:28 AM, Staff I stated that when she signed the narcotic book it indicated the accurate dosing and the amount of the medication left in the supply. She reported if she signed the book that's the amount that remained. She confirmed when she signed the Narcotic book on 9/13/24 for R#89 and R#90 the amount she listed reflected the correct amount of the medication that remained. She reported if she found a controlled/narcotic mediation discrepancy with the count she would call the Director of Nursing (DON) or manager and not even take the keys from the nurse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/08/25 at 11:27 AM, Staff D, RN confirmed she worked from 8:30 PM on 9/13/24 to 6 AM on 9/14/24. She reported she came to the shift as an agency nurse. The other nurse she took over for told her Staff A, RN took a long time to complete her documentation and directed Staff D to start her work. The other nurse told her Staff A would find her for shift report and narcotic/controlled count. Staff D reported some short-term narcotic medication were past the order date and needed destroyed. Staff D stated Staff A read the count she found the narcotics were significantly lower than what Staff A said for Resident #89 and Resident #90. She reported she refused to sign the count sheets. She stated Staff A told her that it was fine and Staff A documented count correction on the record. Staff D reported she told Staff A she needed to reconcile the doses signed out on the Medication Administration Record (MAR) to understand what happened to cross reference. Staff D revealed Staff A declined and told Staff D the facility told us what we needed to do is document count correction on the record. She identified concern that Staff A, failed to notify the DON or nurse manager. She reported she texted the Staff B, DON at the time, and alerted her of the discrepancy in the narcotic count. Staff D reported Staff A continued to work on documentation at the facility until around 2 AM. Staff D reported Staff A looked as if she was falling asleep and her eyes were glazed over. The Video surveillance provided by the facility dated 9/14/24 at 12:04:41 AM Staff A removed 2 boxes approximately 4 inches tall, 2 inches wide by 1 inch deep from the back-left corner of the med room she held them. Staff A pointed out the something on the boxes to Staff D. Staff D in the medication room with Staff A wasted pills in the drug buster solution. At 12:07:17 AM Staff A carried the 2 boxes and the medication cards out of the medication room to the medication cart. At 12:13:57 Staff A went to the left of the medication cart, got a pink bag, put it over her right shoulder and went to the med cart. At 12:14:33 Staff A took the two boxes from the top of the medication cart walked back over to where the bag hung before and placed the 2 boxes inside of the pink bag that she re-hung. The Video surveillance provided by the facility dated 9/19/24 at 7:38-7:40 PM, a nurse at the medication cart, Staff A, carried a hot pink cup into the medication room while she appeared to remove two boxes from her pocket approximately 4 inches tall, 2 inches wide by 1 inch deep. Then Staff A went to the sink in the medication room appeared to place some water in the hot pink cup held in reflection of the glass in the door. Staff A appeared to get into one of the boxes remove a bottle, opened the lid and at 7:39:36 dropped some drops to the cup, placed the bottle back into the box. At 7:40:16 Staff A put the lid back on the cup. She sat at the nurse's desk and drank from the cup. Video surveillance provided by the facility dated 9/19/24 at 10:05:14 PM, Staff A stood in the corner of the 200 Wing Medication Room out of the view of the camera, at 10:05:15 with something in her right hand she turned to the door. Staff A put her left hand in her left pocket and held her right hand near the door. Staff A held something with a dark top and a dark bottom in her right hand. The nurse moved the item from her right hand to her left put her empty right hand in her pocket she took the hot pink cup from the desk in the medication room with her left hand and left the room at 10:05:23 PM. At 10:05:23 Staff A removed the lid from the hot pink cup and set it on top of the medication cart. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:05:33 Staff A removed the hot pink cup from the top of the cart and took it out of view on the 200 Wing. At 10:05:52 Staff A moved a hot pink cup/mug back to the medication cart. At 10:05:54 PM Staff A opened a small bottle, she looked around, she used a dropper and appeared to put drops in the hot pink drink cup as she poured from the bottle into the hot pink cup shaking the bottle upside down. At 10:06:08 she replaced the lid onto the bottle and moved out of the view of the camera but not into the view of the next window. She reentered the camera view, placed the lid on the hot pink cup, and drank from the cup. The Video surveillance dated 9/19/24 at 11:01-11:02 On 200 Wing Video showed Staff A at the medication cart and Staff C walked in the medication room at 11:01:45 Staff A appeared to stagger, hung onto the door, swayed back and forth while the other nurse placed a jug under the sink wiped off the counter and rinsed her hands. At 11:02:34 they both exited the med room and went to the medication cart. On 1/08/25 at 2:27 PM, Staff H reported the E-kit locked and secure at the end of her shift on 9/19/24. She stated she failed to know of any discrepancies, her count was correct if she signed the book. On 1/07/25 at 6:47 PM, Staff E, Certified Nurses Aid (CNA) confirmed she worked on the night shift on 9/19/24. She reported Staff C, LPN paged her to come and help Staff A get to a place she could rest. Staff E revealed Staff A's eyes were glassy and she staggered as she walked. Staff C compared Staff A to a streetwalker that was going to fall over with their wobbly legs. Staff C reported she got a 4 wheeled walker with a seat for Staff A to sit on and she moved her into the conference room to get some rest before she drove home. Staff C stated she asked Staff A if she needed medical attention, but Staff A told her she worked too much and needed rest. Staff C reported Staff A's speech seemed slurred. Staff E stated she thought Staff A may fall and could not drive the way she was. Staff E reported She woke her up about 3-4 she said she was better and left the building after she got her coat and purse. Staff E said Staff A went to her car reclined the seat and one of the day shift staff got there and checked on her. Staff E revealed she called the Chief Operating Officer and reported the behavior of Staff A. On 1/8/25 at 6:30 AM, Staff C, LPN confirmed she worked 9/19/24, 6 PM on the other side of the building and at 10 PM took the rest of the building for the night until 6 AM. She reported she and Staff F, Medication Aid planned to count narcotic/controlled medication and destroy some medication after a death in the facility. She revealed Staff A immediately went right for the narcotic/controlled medication first, she indicated normally they do shift to shift report first. Staff C stated she walked into the medication room and Staff A had a bottle of Ativan or morphine open she poured and spilt it on the cart. Staff C thought Staff A seemed disorientated. Staff C said Staff A told her she was fine, but Staff A popped pills all over the place, they were flying. Staff C asked Staff A again if she was alright. Staff C reported Staff A was generally a slower moving person, but she stopped and looked like she drifted off. Staff C revealed she told her to sit down as she was dozing off while she talked. Staff A walked but seemed in slow motion. The CNA took Staff A to the conference room. Staff C reported she got to the unit around 10 and she thinks Staff A got out of the Wing around 10:30. Staff C said she didn't know she slept in the conference room until 2 AM. She said she didn't know what to do but let her sleep. She reported to the day shift after they asked if she stayed all night. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/08/25 at 1:09 PM, the Restorative nurse confirmed she got to the facility early in the AM on 9/20/24 and saw Staff A slumped over in the front seat of her car. She reported she thought someone went out on break and fell asleep. The Restorative nurse stated she knocked on the window of the car to wake Staff A. She reported Staff A's slurred speech and she told her she was tired. The Restorative nurse offered her a ride home and Staff A declined. On 01/08/25 at 7:33 PM, Staff B, Previous DON, reported she failed to identify any concerns with the nurses at the facility. She reported she received a text from one nurse about a hospice resident's morphine count that maybe was off. She revealed she got sick and forgot to look into it further. She stated she failed to know of the incident on 9/19/24 until in the mid-afternoon on 9/20/24. On 1/9/25 at 10:08 AM, the DON reported after the event on 9/19/24, she alerted the Pharmacy to review the records and the Emergency drug kit (E-Kit). She stated she thought they came and picked up the E-kit that Friday. She revealed the pharmacy called her the next week and reported 2 oxycodone tablets gone from the e-Kit with no order or explanation where they went. 01/09/25 02:51 PM, the DON reported she expected the nurses to count and sign the narcotic records to reflect an accurate count. She reported if the nurses found a discrepancy she expected staff to notify her immediately. The facility provided a policy titled Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy dated 10/2022, directed all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property. These procedures shall include the screening and training of employees, protection of residents and the prevention, identification, investigation, and timely reporting of abuse, neglect, mistreatment, and misappropriation of property, without fear of recrimination or intimidation. Exploitation of a dependent adult. Exploitation means a caretaker knowingly obtains, uses, endeavors to obtain to use or who misappropriates a dependent adult's funds, assets, medications, or property with the intent to temporarily or permanently deprive a dependent adult of the use, benefit, or possession of the funds, assets, medication or property for the benefit of someone other than the dependent adult Misappropriation of Resident property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a Resident's belongings or money without the Resident's consent. This includes misappropriation or diversion of resident medications. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on clinical record review, staff interviews, and facility policy review the facility failed to implement Abuse Prevention policies for an investigation into reported misappropriated resident medications for 2 out of 3 residents reviewed (Residents #89 and #90). The facility reported a censes of 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #89 dated 7/18/24, listed diagnoses of non-Alzheimer's dementia, Parkinson's disease, and seizure disorder. The Brief Interview for Mental Status (BIMS) reflected a score of 1, severe cognitive impairment. The Care Plan for R#89 dated 4/26/24, directed staff to administer medications as ordered. Monitor and record effectiveness. Report any adverse side effects. The Controlled Substance Count & Usage Record for R#89 dated 9/13/24 at 2:00 PM reflected 24 milliliters (ml) of Morphine remained at the shift change cosigned by Staff I, Licensed Practical Nurse (LPN) and Staff A, Registered Nurse (RN). The next entry on the document dated 9/13/24 at 10 PM, reflected 22 ml remained. The record failed to reflect 2 ml of the Morphine being administered. The document revealed a note on the left side of the form count corrected The document failed to give an explanation of what happened to the 2 ml of Morphine. The Medication Administration Record (MAR) dated 9/13/2024, listed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 5 mg by mouth every 4 hours as needed (PRN) for Pain 0.25 ml or 5 mg every 4 hours as needed for pain and lacked a dose signed out/administered. 2. The MDS for Resident #90 dated 8/8/24, listed diagnoses of non-Alzheimer's dementia, diabetes mellitus, and heart failure. The MDS revealed a BIMS score of 00, indicated sever cognitive impairments. The Care Plan for Resident #90 dated 6/24/24, directed staff to administer medications as ordered. The Controlled Substance Count & Usage Record for R#90 dated 9/13/24 at 2 PM, listed 8.75 ml of morphine remained. The record reflected Staff A, RN administered two 0.25 ml doses of the Morphine to Resident #90. One 0.25 ml dose at 2:57 PM and one 0.25 ml dose at 8:40 PM. The count at that time reflected 8.25 ml. At 10 PM the end of the shift count (CT) reflected 8.25 ml. The next line on the form revealed count correction 6 ml morphine remained. The document failed to explain why the count failed to include the location of the missing 2.25 ml. The MAR dated 9/2024, directed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 0.25 ml by mouth three times a day for pain. The MAR also listed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 0. 25 ml by mouth every 2 hours as needed for Pain or dyspnea, none signed out PRN on 9/13/24. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/08/25 at 11:27 AM, Staff D, RN confirmed she worked from 8:30 PM on 9/13/24 to 6 AM on 9/14/24. She reported she came to the shift as an agency nurse. The other nurse she took over for told her Staff A, RN took a long time to complete her documentation and directed Staff D to start her work. The other nurse told her Staff A would find her for shift report and narcotic/controlled count. Staff D reported some short-term narcotic medications were past the order date and needed to be destroyed. Staff D stated Staff A read the count she found the narcotics were significantly lower then what Staff A said for Resident #89 and Resident#90. She reported she refused to sign the count sheets. She stated Staff A told her that it was fine and Staff A documented count correction on the record. Staff D reported she told Staff A she needed to reconcile the doses signed out on the Medication Administration Record (MAR) to understand what happened to cross reference. Staff D revealed Staff A declined and told Staff D the facility told us what we needed to do is document count correction on the record. She identified a concern that Staff A, failed to notify the DON or nurse manager. She reported she texted Staff B, DON at the time, and alerted her of the discrepancy in the narcotic count. Staff D reported Staff A continued to work on documentation at the facility until around 2 AM. Staff D reported Staff A looked as if she was falling asleep and her eyes were glazed over. On 01/08/25 at 7:33 PM, Staff B, previous DON, reported she failed to identify any concerns with the nurses at the facility. She reported she received a text from one nurse about a hospice resident's morphine count that maybe was off. She revealed she got sick and forgot to look into it further. She stated she failed to know of the incident on 9/19/24 until in the mid-afternoon on 9/20/24. The facility provided a policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated 10/2022. These procedures shall include the screening and training of employees, protection of residents and the prevention, identification, investigation, and timely reporting of abuse, neglect, mistreatment, and misappropriation of property, without fear of recrimination or intimidation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review, staff interviews, and facility policy review the facility failed to report misappropriation of 2 out of 3 resident's medications (Resident #89, and #90) to the State Agency (SA) and law enforcement. The facility reported a census of 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #89 dated 7/18/24, listed diagnoses of non-Alzheimer's dementia, Parkinson's disease, and seizure disorder. The Brief Interview for Mental Status (BIMS) reflected a score of 1, severe cognitive impairment. The Care Plan for R#89 dated 4/26/24, directed staff to administer medications as ordered. Monitor and record effectiveness. Report any adverse side effects. The Controlled Substance Count & Usage Record for R#89 dated 9/13/24 at 2:00 PM reflected 24 milliliters (ml) of Morphine remained at the shift change cosigned by Staff I, Licensed Practical Nurse (LPN) and Staff A, Registered Nurse (RN). The next entry on the document dated 9/13/24 at 10 PM, reflected 22 ml remained. The record failed to reflect 2 ml of the Morphine as administered. The document revealed a note on the left side of the form count corrected The document failed to give an explanation of what happened to the 2 ml of missing Morphine. The Medication Administration Record (MAR) dated 9/13/2024, listed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 5 mg by mouth every 4 hours as needed (PRN) for Pain 0.25 ml or 5 mg every 4 hours as needed for pain and lacked a dose signed out/administered. 2. The MDS for Resident #90 dated 8/8/24, listed diagnoses of non-Alzheimer's dementia, diabetes mellitus, and heart failure. The MDS revealed a BIMS score of 00, indicated sever cognitive impairments. The Care Plan for Resident #90 dated 6/24/24, directed staff to administer medications as ordered. The Controlled Substance Count & Usage Record for R#90 dated 9/13/24 at 2 PM, listed 8.75 ml of morphine remained. The record reflected Staff A, RN administered two 0.25 ml doses of the Morphine to Resident #90. One 0.25 ml dose at 2:57 PM and one 0.25 ml dose at 8:40 PM. The count at that time reflected 8.25 ml. At 10 PM the end of the shift count (CT) reflected 8.25 ml. The next line on the form revealed count correction 6 ml morphine remained. The document failed to explain why the count failed to include the location of the missing 2.25 ml of morphine. The MAR dated 9/2024, directed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 0.25 ml by mouth three times a day for pain. The MAR also listed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 0. 25 ml by mouth every 2 hours as needed for Pain or dyspnea, none signed out PRN on 9/13/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/08/25 at 11:27 AM, Staff D, RN confirmed she worked from 8:30 PM on 9/13/24 to 6 AM on 9/14/24. She reported she came to the shift as an agency nurse. The other nurse she took over for told her Staff A, RN took a long time to complete her documentation and directed Staff D to start her work. The other nurse told her Staff A would find her for shift report and narcotic/controlled count. Staff D reported some short-term narcotic medications were past the order date and needed to be destroyed. Staff D stated Staff A read the count, she found the narcotics were significantly lower than what Staff A said for Resident #89 and Resident #90. She reported she refused to sign the count sheets. She stated Staff A told her that it was fine and Staff A documented count correction on the record. Staff D reported she told Staff A she needed to reconcile the doses signed out on the Medication Administration Record (MAR) to understand what happened to cross reference. Staff D revealed Staff A declined and told Staff D the facility told us what we needed to do is document count correction on the record. She identified a concern that Staff A, failed to notify the DON or nurse manager. She reported she texted Staff B, DON at the time, and alerted her of the discrepancy in the narcotic count. Staff D reported Staff A continued to work on documentation at the facility until around 2 AM. Staff D reported Staff A looked as if she was falling asleep and her eyes were glazed over. On 01/08/25 at 7:33 PM, Staff B, previous DON, reported she failed to identify any concerns with the nurses at the facility. She reported she received a text from one nurse about a hospice resident's morphine count that maybe was off. She revealed she got sick and forgot to look into it further. She stated she failed to know of the incident on 9/19/24 until in the mid-afternoon on 9/20/24. On 01/09/25 at 1:33 PM, Staff L, Chief Executive Officer (CEO) reported the previous Director of Nursing (DON) failed to report the inaccurate narcotic counts for Resident #89 and #90 to the Administrator for further investigation and reporting. The facility provided a policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated 10/2022, directed all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property. These procedures shall include the screening and training of employees, protection of residents and the prevention, identification, investigation, and timely reporting of abuse, neglect, mistreatment, and misappropriation of property, without fear of recrimination or intimidation. All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative. All allegations of Resident abuse shall be reported to SA not later than two (2) hours after the allegation is made. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165621	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens of Cedar Rapids	5710 Dean Road SW Cedar Rapids, IA 52404

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All allegations of Resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the SA, not later than two (2) hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or not later than twenty-four (24) hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury. If there is a reasonable suspicion that the allegation of abuse also constitutes a crime committed against the resident by any person, whether or not the alleged perpetrator is employed by the facility, the Elder Justice Act requires the matter must also be reported to law enforcement. While the federal regulations require all abuse allegations be reported to SA within 2 hours, the Elder Justice Act has a different time frame for reporting to the police/sheriff. If the allegation of abuse (that results from a crime) results in serious bodily injury to a resident, a report must be made to law enforcement not later than two (2) hours after the allegation is made. If the allegation of abuse does not result in serious bodily injury, a report must be made to law enforcement not later than twenty-four (24) hours (See Elder Justice Act requirements on page 9). A report shall be made by calling the SA reporting hotline, submitting an e-mail to the, submitting an online report or sending a fax. If the person in charge is the alleged abuser, the staff member shall directly report the abuse to the SA immediately, pursuant to the deadlines established above. If the allegations of dependent adult abuse involve a caretaker who is not an employee of the facility (e.g. family member, visitor), a report must also be made immediately to both the DIA and DHS.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on clinical record review, staff interviews, and facility policy review the facility failed to investigate a reported incident of misappropriated resident medications for 2 of 3 residents reviewed (Resident#89, and 90) and failed to prevent further misappropriation of medication of 1 resident (Resident #92). The facility reported a census 35 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #89 dated 7/18/24, listed diagnoses of non-Alzheimer's dementia, Parkinson's disease, and seizure disorder. The Brief Interview for Mental Status (BIMS) reflected a score of 1, severe cognitive impairment. The Care Plan for Resident#89 dated 4/26/24, directed staff to administer medications as ordered. Monitor and record effectiveness. Report any adverse side effects. The Controlled Substance Count & Usage Record for R#89 dated 9/13/24 at 2:00 PM reflected 24 milliliters (ml) of Morphine remained at the shift change cosigned by Staff I, Licensed Practical Nurse (LPN) and Staff A, Registered Nurse (RN). The next entry on the document dated 9/13/24 at 10 PM, reflected 22 ml remained. The document revealed a note on the left side of the form count corrected The document failed to an explanation of what happened to the 2 ml of Morphine. The Medication Administration Record (MAR) dated 9/13/2024, listed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 5 mg by mouth every 4 hours as needed (PRN) for Pain 0.25 ml or 5 mg every 4 hours as needed for pain. Lacked a dose signed out/ administered. 2. The MDS for Resident #90 dated 8/8/24, listed diagnoses of non-Alzheimer's dementia, diabetes mellitus, and heart failure. The MDS revealed a BIMS score of 00, indicated sever cognitive impairments. The Care Plan for Resident #90 dated 6/24/24, directed staff to administer medications as ordered. The Controlled Substance Count & Usage Record for R#90 dated 9/13/24 at 2 PM, listed 8.75 ml of morphine remained. The record reflected Staff A, RN administered two 0.25 ml doses of the Morphine to Resident #90. One 0.25 ml dose at 2:57 PM and one 0.25 ml dose at 8:40 PM. The count at that time reflected 8.25 ml. At 10 PM the end of the shift count (CT) reflected 8.25 ml. The next line on the form revealed count correction 6 ml morphine remained. The document failed to explain why the count failed to include the location of the missing 2.25 ml. The MAR dated 9/2024, directed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 0.25 ml by mouth three times a day for pain. The MAR also listed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 0. 25 ml by mouth every 2 hours as needed for Pain or dyspnea, none signed out PRN on 9/13/24. 3. The MDS for Resident #92 dated 9/12/24, listed diagnoses of lung cancer, non-Alzheimer's dementia, arthritis, and diabetes mellitus. Resident #92's MDS reflected her BIMS score of 15, intact cognition. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan for R#92 dated 9/19/24, directed use pain management as appropriate. Monitor/document side effects and effectiveness. The MAR dated 9/19/24, directed Ativan Solution 2 MG/ML (lorazepam). Give 0.5 mg sublingually every 2 hours for terminal pass. The Controlled Substance Count & Usage Record for R#92 dated 9/19/24 at 12:35 PM showed 29.5 ml of morphine solution, staff gave 0.25 ml that left 29.25 ml. The next time on the record reflected 2 PM, and 28. 75 ml remained. The count failed to reflect 0.5 ml of the morphine solution discrepancy. The Controlled Substance Count & Usage Record for R#92 dated 9/19/24 at 5:45 PM showed 29.5 remained of the Ativan Solution. After 0.5 ml administered the count reflected the amount that remained as 27 ml. Review of the Daily Assignment sheet dated 9/13/24, listed Staff I, Licensed Practical Nurse (LPN), worked 6 to 2 PM, Staff A, Registered Nurse (RN) worked 2 PM to 10 PM and Staff D, RN worked the 10 PM to 6 AM shift. The medication signed out 4 times on the shift. Review of the Daily Assignment sheet dated 9/19/24, listed Staff H, RN worked the 6 AM to 2 PM shift, Staff, A worked the 2 PM to 10 PM shift and Staff D, LPN worked 10 PM to 6 AM shift. On 1/9/24 at 9:28 AM, Staff I stated that when she signed the narcotic book it indicated the accurate dosing and the amount of the medication left in the supply. She reported if she signed the book that's the amount that remained. She confirmed when she signed the Narcotic book on 9/13/24 for R#89 and R#90 the amount she listed reflected the correct amount of the medication that remained. She reported if she found a controlled/narcotic mediation discrepancy with the count she would call the Director of Nursing (DON) or manager and not even take the keys from the nurse. On 01/08/25 at 11:27 AM, Staff D, RN confirmed she worked from 8:30 PM on 9/13/24 to 6 AM on 9/14/24. She reported she came to the shift as an agency nurse. The other nurse she took over for told her Staff A, RN took a long time to complete her documentation and directed Staff D to start her work. The other nurse told her Staff A would find her for shift report and narcotic/controlled count. Staff D reported some short-term narcotic medication were past the order date and needed destroyed. Staff D stated Staff A read the count she found the narcotics were significantly lower then what Staff A said for Resident #89 and Resident #90. She reported she refused to sign the count sheets. She stated Staff A told her that it was fine and Staff A documented count correction on the record. Staff D reported she told Staff A she needed to reconcile the doses signed out on the Medication Administration Record (MAR) to understand what happened to cross reference. Staff D revealed Staff A declined and told Staff D the facility told us what we needed to do is document count correction on the record. She identified a concern that Staff A, failed to notify the DON or nurse manager. She reported she texted the Staff B, DON at the time, and alerted her of the discrepancy in the narcotic count. Staff D reported Staff A continued to work on documentation at the facility until around 2 AM. Staff D reported Staff A looked as if she was falling asleep and her eyes were glazed over. On 1/08/25 at 2:27 PM, Staff H reported the E-kit was locked and secure at the end of her shift on 9/19/24. She stated she failed to know of any discrepancies, her count was correct if she signed the book. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/07/25 at 6:47 PM, Staff E, Certified Nurses Aid (CNA) confirmed she worked on the night shift on 9/19/24. She reported Staff C, LPN paged her to come and help Staff A get to a place she could rest. Staff E revealed Staff A's eyes were glassy and she staggered as she walked. Staff C compared Staff A to a streetwalker that was going to fall over with their wobbly legs. Staff C reported she got a 4 wheeled walker with a seat for Staff A to sit on and she moved her into the conference room to get some rest before she drove home. Staff C stated she asked Staff A if she needed medical attention, but Staff A told her she worked too much and needed rest. Staff C reported Staff A's speech seemed slurred. Staff E stated she thought Staff A may fall and could not drive the way she was. Staff E reported She woke her up about 3-4 AM she said she was better and left the building after she got her coat and purse. Staff E said Staff A went to her car reclined the seat and one of the day shift staff got there and checked on her. Staff E revealed she called the Chief Operating Officer and reported the behavior of Staff A. On 1/8/25 at 6:30 AM, Staff C, LPN confirmed she worked 9/19/24, 6 PM on the other side of the building and at 10 PM took the rest of the building for the night until 6 AM. She reported she and Staff F, Medication Aid planned to count narcotic/controlled medication and destroy some medication after a death in the facility. She revealed Staff A immediately went right for the narcotic/controlled medication first, she indicated normally they do shift to shift report first. Staff C stated she walked into the medication room and Staff A had a bottle of Ativan or morphine open she poured and spilt it on the cart. Staff C thought Staff A seemed disorientated. Staff C said Staff A told her she was fine, but Staff A popped pills all over the place they were flying. Staff C asked Staff A again if she was alright. Staff C reported Staff A was generally a slower moving person, but she stopped and looked like she drifted off. Staff C revealed she told her to sit down as she was dozing off while she talked. Staff A walked but seemed in slow motion. The CNA took Staff A to the conference room. Staff C reported she got to the unit around 10 PM and she thinks Staff A got out of the Wing around 10:30 PM. Staff C said she didn't know she slept in the conference room until 2 AM. She said she didn't know what to do but let her sleep. She reported to the day shift after they asked if she stayed all night. On 1/08/25 at 1:09 PM, the Restorative nurse confirmed she got to the facility early in the AM on 9/20/24 and saw Staff A slumped over in the front seat of her car. She reported she thought someone went out on break and fell asleep. The Restorative nurse stated she knocked on the window of the car to wake Staff A. She reported Staff A's slurred speech and she told her she was tired. The Restorative nurse offered her a ride home and Staff A declined. On 01/08/25 at 7:33 PM, Staff B, previous DON, reported she failed to identify any concerns with the nurses at the facility. She reported she received a text from one nurse about a hospice resident's morphine count that maybe was off. She revealed she got sick and forgot to look into it further. She stated she failed to know of the incident on 9/19/24 until in the mid-afternoon on 9/20/24. On 1/9/24 at 10:08 AM, the DON reported after the event on 9/19/24, she alerted the Pharmacy to review the records and the Emergency drug kit (E-Kit). She stated she thought they came and picked up the E-kit that Friday. She revealed the pharmacy called her the next week and reported 2 oxycodone tablets gone from the e-Kit with no order or explanation where they went. 01/09/25 02:51 PM, the DON reported she expected the nurses to count and sign the narcotic records to reflect an accurate count. She reported if the nurses found a discrepancy she expected staff to notify her immediately. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided a policy titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated 10/2022, directed all residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property. These procedures shall include the screening and training of employees, protection of residents and the prevention, identification, investigation, and timely reporting of abuse, neglect, mistreatment, and misappropriation of property, without fear of recrimination or intimidation. Exploitation of a dependent adult. Exploitation means a caretaker knowingly obtains, uses, endeavors to obtain to use or who misappropriates a dependent adult's funds, assets, medications, or property with the intent to temporarily or permanently deprive a dependent adult of the use, benefit, or possession of the funds, assets, medication or property for the benefit of someone other than the dependent adult Misappropriation of Resident property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a Resident's belongings or money without the Resident's consent. This includes misappropriation or diversion of resident medications. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Investigation Protocols Should an incident or suspected incident of Resident abuse (as defined above) be reported or observed, the administrator or his/her designee will designate a member of management to investigate the alleged incident. The administrator or designee will complete documentation of the allegation of Resident abuse and collect any supporting documents relative to the alleged incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, clinical record review, staff interview and facility policy review the facility failed to accurately account for controlled/narcotic medications for 3 of the 3 residents reviewed (Residents #89, #90, and #92). The facility reported a census of 35 residents. Finding include: 1. The Minimum Data Set (MDS) assessment for Resident #89 dated 7/18/24, listed diagnoses of non-Alzheimer's dementia, Parkinson's disease, and seizure disorder. The Brief Interview for Mental Status (BIMS) reflected a score of 1, severe cognitive impairment. The Care Plan for R#89 dated 4/26/24, directed staff to administer medications as ordered. Monitor and record effectiveness. Report any adverse side effects. The Controlled Substance Count & Usage Record for R#89 dated 9/13/24 at 2:00 PM, reflected 24 milliliters (ml) of Morphine solution remained at the shift change cosigned by Staff I, Licensed Practical Nurse (LPN) and Staff A, Registered Nurse (RN). The next entry on the document dated 9/13/24 at 10 PM, reflected 22 ml remained of the Morphine solution. The document revealed a note on the left side of the form count corrected. The document failed to give an explanation of what happened to the missing 2 ml of Morphine. The Medication Administration Record (MAR) dated 9/13/2024, listed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 5 mg by mouth every 4 hours as needed (PRN) for Pain 0.25 ml or 5 mg every 4 hours as needed for pain. Lacked a dose signed out/ administered. 2. The MDS for Resident #90 dated 8/8/24, listed diagnoses of non-Alzheimer's dementia, diabetes mellitus, and heart failure. The MDS revealed a BIMS score of 00, indicated sever cognitive impairments. The Care Plan for R#90 dated 6/24/24, directed staff to administer medications as ordered. The Controlled Substance Count & Usage Record for R#90 dated 9/13/24 at 2 PM, listed 8.75 ml of morphine remained. The record reflected Staff A, RN administered two 0.25 ml doses of the Morphine to Resident #90. One 0.25 ml dose at 2:57 PM and one 0.25 ml dose at 8:40 PM. The count at that time reflected 8.25 ml. At 10 PM the end of the shift count (CT) reflected 8.25 ml. The next line on the form revealed count correction 6 ml morphine remained. The document failed to explain why the count failed to include the location of the missing 2.25 ml. The MAR dated 9/2024, directed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 0.25 ml by mouth three times a day for pain. The MAR also listed Morphine Sulfate (Concentrate) Solution 20 MG/ML. Give 0. 25 ml by mouth every 2 hours as needed for Pain or dyspnea. The MAR lacked a PRN dose administered on 9/13/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The MDS for Resident #92 dated 9/12/24, listed diagnoses of lung cancer, non-Alzheimer's dementia, arthritis, and diabetes mellitus. Resident #92's MDS reflected her BIMS score of 15, intact cognition. The Care Plan for R#92 dated 9/19/24, directed staff to use pain management as appropriate. Monitor/document side effects and effectiveness. The MAR dated 9/19/24, directed Ativan (lorazepam) Solution 2 milligrams (mg)/ml. Give 0.5 mg sublingually (under the tongue) every 2 hours for terminal pass. The Controlled Substance Count & Usage Record for R#92 dated 9/19/24 at 12:35 PM showed 29.5 ml of morphine solution, staff gave 0.25 ml that left 29 ml. The next time on the record reflected 2 PM, and 28.75 ml remained. The count failed to reflect the 0.25 ml discrepancy of the morphine solution. The Controlled Substance Count & Usage Record for R#92 dated 9/19/24 at 5:45 PM showed 29.5 remained of the Ativan Solution. After 0.5 ml administered the count reflected the amount that remained as 29 ml. The next entry on the document dated 9/19/24 at 10 PM revealed 29 ml on hand with nothing given at the time and 27 ml remained. The document lacked an explanation what happened to the 2 ml unaccounted for. Review of the Daily Assignment sheet dated 9/13/24, listed Staff I, Licensed Practical Nurse (LPN), worked 6-2 PM and Staff A, Registered Nurse (RN) worked 2-10 PM and Staff D, RN worked the 10-6 AM shift. The medication signed out 4 times on the shift. 4. Observation on 1/06/25 at 2:05 PM, Staff I, Licensed Piratical Nurse from day shift stood at the end of the medication cart and read the numbers from the Narcotic book while Staff J, LPN the evening nurse knelt at the bottom drawer of the medication cart confirmed the number of narcotic medications that remained in the drawer. Staff I failed to make visual confirmation of the medication that remained in the drawer. On 9/9/24 at 9:28 AM, Staff I reported the process to count narcotic and controlled medication required 2 nurses will look at the amount and look at the book. She stated that when she signed the narcotic book it indicated the accurate dosing and the amount of the medication left in the supply. She reported if she signed the book that's the amount that remained. She confirmed when she signed the Narcotic book on 9/13/24 for R#89 and R#90 the amount she listed reflected the correct amount of the medication that remained. She reported if she found a narcotic discrepancy with the count she would call the DON or manager and not even take the keys from the nurse. On 1/09/25 02:51 PM the Director of Nursing (DON) confirmed she expected the medication carts locked at all times. The DON reported she expected the nurses to count and sign the narcotic records to reflect an accurate count. She reported if the nurses found a discrepancy she expected staff to notify her immediately. The DON stated if a discrepancy is found she will let the Administrator know and an investigation initiated. The facility provided a policy titled Controlled Substances dated 5/2024, the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. The director of nursing services documents irreconcilable discrepancies in a report to the administrator. If a major discrepancy or a pattern of discrepancies occurs, or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist immediately. The director of nursing services consults with the provider pharmacy and the administrator to determine whether any further legal action is indicated. Some controlled substances may be stored in the emergency medication supply. Reconciliation of controlled substances in the emergency supply is conducted at intervals established by the director of nursing services. The director of nursing services maintains and disseminates to appropriate individuals a list of staff who have access to medication storage areas and controlled substance containers.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, and facility policy review the facility failed to securely store medication 2 out of 2 times on 1 out of 2 medication carts on 1 out of 4 days observed. The facility reported a census of 35 residents. Finding include: 1. On 1/07/25 at 10:39 AM, the 200 Wing medication cart sat unlocked in the lounge area. 5 residents sat in the area in recliners with their feet up. Between 10:39 and 10:47 AM, 4 people walked by the unlocked medication cart. On 1/07/25 at 10:48 AM, Staff K, Licensed Practical Nurse (LPN), came to the medication cart from a Residents room. She reported she doesn't normally leave the medication cart unlocked. 2. On 1/07/25 at 10:57 AM the medication cart sat in the 200-lounge unlocked. On 1/07/25 at 10:59 AM Staff K, walked back down from the dining room area, and locked the medication cart. On 1/09/25 at 2:51 PM, the Director of Nursing (DON) confirmed she expected the medication carts locked at all times. The Medication Labeling and Storage policy dated 10/2023, directed the facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.