DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165325	A. BUILDING _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR HOUSE CARE CENTER	1212 SOUTH STUART STREET SIGOURNEY, IA 52591

(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 000 ✓ ok/cp	INITIAL COMMENTS Correction date: August 12, 2023 The following deficiencies resulted from the facility's Annual Recertification Survey and investigation of complaints #111704-C- # and Facility Reported Incidents #107347-I, conducted July 10, 2023 to July 13, 2023. Facility reported incident #107347-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review the facility failed to ensure residents were free from neglect when 24 of 24 residents (Resident #104, #105, #106, #107, #108, #109,	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sierra Ackerman | TITLE: Administrator | (X6) DATE: 7/28/23

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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#110, #111, #112, #54, #39, #14, #22, #113, #20, #15, #5, #31, #17, #114, #18, #115, #13, and #14) did not receive their scheduled medications including, narcotics, insulin, antibiotics, blood pressure, psychotropic, respiratory and blood thinner medications on 7/4/2022 by Staff A, Licensed Practical Nurse (LPN) who was their nurse from 2:00 PM to 6:00 AM on 7/5/22. The facility reported a census of 51 residents.

Findings include:

Record review of a document created by the facility titled, Medications Documented as Administered by Staff A on 7/4/2022, documented the following 24 residents failed to receive the following medications on 7/4/22 while Staff A was working.

1. Resident #104
Flomax 0.4 mg
Levemir 100 unit/ml 35 units
Metformin HCl 500 mg
Metoprolol Tartrate 50 mg
Cephalexin Capsule 250 mg
Citalopram Hydrobromide Tablet 20 mg
Colace Capsule 100 mg

2. Resident #105
Donepezil 5 mg Mirtazapine 7.5 mg
Simvastatin 20 mg
Atenolol 12.5 mg

3. Resident #106
Docusate Sodium 100 mg
Famotidine 20 mg
Magox 400
Mighty Shake (supplement)
Hydrocodone-Acetaminophen 7.5-325 mg

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Hydrocodone-Acetaminophen 7.5-325 mg

4. Resident #107
Senna 8.6 mg
Baclofen 10 mg

5. Resident #108
Carbidopa-Levodopa 25-100 mg (1.5 tablet)
NovoLOG 10 units
Ascorbic Acid 500 mg
Ferrous Sulfate 325 mg
Gabapentin Capsule 300 mg
Insulin Glargine 30 units
Pravastatin Sodium 40 mg
Combigan Solution 0.2-0.5% 1 drop right eye
Tylenol 325 mg

6. Resident #109
Acetaminophen 650 ER
Atenolol 25 mg

7. Resident #110
Mirtazapine 30 mg

8. Resident #111
Carbidopa-Levodopa 25-100 mg (2 tablets)
Sennosides-Docusate Sodium 8.6-50 mg
Venlafaxine 37.5 mg
Clonazepam 1 mg
Seroquel 25 mg
Seroquel 50 mg
Carbidopa-Levodopa 25-100 mg (2 tablets)

9. Resident #112
Cholecalciferol 1000 Pravastatin 20 mg
Metoprolol Tartrate 25 mg
Refresh Optive PF Solution 0.5-0.9% 1 drop both eyes
Senna Tablet 8.5 mg

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Latanoprost 1 drop both eyes
Nifedipine ER 90 mg
Preservision AREDS 2 Tablet
Acetaminophen 650 mg ER
Brimonidine Tartrate-Timolol 1 drop both eyes
Lidocaine Cream 4% right neck Lidocaine Patch 4%

10. Resident #54
Cymbalta 30 mg
Donepezil 10 mg
Memantine 10 mg
(1700) Cholestyramine 4 gram
Potassium Chloride liquid 20 meq/15 ml
Eye supplement 2 Capsule
Saline Nasal Spray

11. Resident #39
Cranberry Tablet 450 mg
Docusate Sodium Capsule 100 mg Pentoxlfyline ER Tablet ER 400 mg
Prostat 300cc
Risperidone Tablet 0.25 mg
Mirtazapine 7.5 mg
Rocklatan Solution 0.02-0.005% 1 drop both eyes
Brimonidine Tartrate Solution 0.15% drop both eyes

12. Resident #14
Mighty Shake 4 oz. (supplement)

13. Resident #22
Eliquis 2.5 mg
Namenda 10 mg
Ocuvite-Lutein
Seroquel tablet 50 mg
Buspirone HCl 7.5 mg
Refresh Solution 1 drop both eyes

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14. Resident #113
Acetaminophen 650 mg ER
Senna 8.6 mg

15. Resident #20
Colace 100 mg
Acetaminophen 650 ER
Calcium - Vit D - Vit K (supplement)
Atorvastatin Calcium Tablet 40 mg
Zyprexa 10 mg

16. Resident #15
Arginaid Extra Liquid 120cc
Metformin HCl ER 500 mg
Oxycabazepine 150 mg
Eliquis 5 mg
Lidocaine Patch 4%
(2000) Acetaminophen tablet 650mg

17. Resident #5
Carvedilol 12.5 mg
Gabapentin capsule 200 mg
Hydralazine HCl tablet 50 mg
Ensure Clear 120cc (supplement)
Hydralazine HCl tablet 50 mg
Acetaminophen tablet 500mg

18. Resident #31
Acetaminophen
Sennosides-Docusate Sodium 8.6-50 mg

19. Resident #17
Metoprolol Tartrate 50 mg
Haloperidol Tablet 0.5 mg
Acetaminophen Tablet 500 mg
Fentanyl Patch 25 mcg/hr

20. Resident #114
Acetaminophen 650 mg ER

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F 600	Continued From page 5 Gabapentin Capsule 300 mg Nexium 20 mg Sennosides-Docusate Sodium 8.6-50 mg Irbesartan 300 mg Melatonin tablet 5 mg Calcium Carbonate-Vitamin D 600-400 mg Lacri-Lube Ophathalmic Ointment to right lower eye lid 21. Resident #18 Budesonide Suspension 0.5 mg/2ml 1 via inhale orally Amlodipine Besylate 5 mg Metoprolol Succinate ER 50 mg Simvastatin 20 mg Ipratropium-albuterol solution 0.5-2.5 (3) mg/ml 22. Resident #115 Pro-Stat (supplement) Quetiapine Fumarate Tablet 25 mg Trazodone HCl 50 mg Tylenol tablet 650 mg Eliquis 5 mg Namenda 10 mg 23. Resident #13 Ocuvite Eye + Multi tablet Acetaminophen ER 650 mg Arginaid Extra Liquid 4 oz. Eliquis Tablet 2.5mg Lexapro 5 mg Acetaminophen ER 650 mg 25. Resident #14 Refresh Tears Solution Muro 128 Ointment 5% Refresh Tears Solution Record review of an undated document created by the facility titled, Timeline, instructed Staff A's	F 600		

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whereabouts during her shift and what she did on 7/4/22 at 2:20 PM to 7/5/22 at 6:00 AM. Through review of the timeline Staff A did not pass medications to residents.

Record review of a document submitted to the [state redacted] Board of Nursing regarding Staff A, by the facility instructed the following:
On 7/5/2022 the Administrator received a concern from a night shift employee that Staff A that worked for a local staffing agency was asleep in the recliner during her 2:00 PM to 6:00 AM shift on 7/4/22. After watching the camera footage, Staff A was asleep from 1:48 AM to 3:40 AM. No other nurse was on duty as this time. During investigation, it was identified that Staff A did not complete her medication administrations that she signed off in the Medication Administration Record (MAR) for multiple residents on 7/4/22. It can be seen in the video cameras that within a 15-minute period, Staff A removed the medications which should have been given on her shift for all assigned residents. She removed the medication cards a few at a time, took out the doses scheduled for her shift, and disposed of them. Some of the medications were put into a medical disposable glove and discarded in the trash. It is unclear via the camera if all medications were thrown in the garbage or if medications could have been kept on her person and stolen. The view is blocked by the laptop on the nurse's cart. Staff A also would have taken out her own trash and disposed of it which is not within sight of the camera. The Administrator also documented she talked to Staff A on 7/5/22 at 6:00 PM via phone that she threw away one resident's medications.

During an interview on 7/12/23 at 3:44 PM with

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the facilities Administrator revealed she received an anonymous note under her door on 7/5/2022 informing her Staff A was sleeping on 7/4/22. She revealed she started to watch the facilities cameras and found there was times she was sitting in the recliner and may have been sleeping. She informed she watched the medication pass and typed up a timeline (Timeline document) of events of exactly what she did to tray an narrow it down. She then revealed she complied a list of residents that did not receive their medications as ordered (Medications Documented as Administered by Staff A on 7/4/2022). She then informed 24 residents did not receive their medications as ordered on 7/4/22. She revealed Staff A was an agency employee that was terminated immediately after this event, but was at the facility for approximately a year and went through all of the facilities normal orientation training. She informed Staff A was well orientated to the facility. She then informed she is unsure of the reason why Staff A did not provide medications to the residents, she informed Staff A worked two (2) prior days that week and they watched the cameras to see if she provided medications on those days and she did, so unsure of why this occurred, this is not what the facility expects of it's employees.

During an interview on 7/13/23 at 9:48 AM with the Director of Nursing (DON) revealed she would of expected Staff A to pass medications to all residents as they were ordered. She revealed Staff A was well trained and worked at the facility for about a year, she informed she does not know why she did not pass the medications as she was not trained that way.

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F 600	Continued From page 8 Record review of the facilites policy titled, Abuse Prevention, Training, and Investigations, last revised on 12/30/20 revealed the facility followed their policy and procedure regarding the neglect that occured for the 24 resident on 7/4/22. The person in charge of the facility shall immediately: a) Separate the alleged perpetrator, if known, from the victim and maintain this separation without exception, pending completion of the investigation; b) Assess the victim for injury requiring immediate medical assistance and provide or arrange for needed care and treatment; c) Implement precautions to preserve physical evidence that might be present at the site and/or on the victim or alleged perpetrator; d) Interview the victim, if possible, for his/her statement related to the occurrence; e) Interview the alleged perpetrator, if known and on-site, to obtain a statement of his/her knowledge and involvement; f) If appropriate due to the seriousness of the allegation, relieve the alleged perpetrator of further work duties and place the person in an unpaid, suspended work status pending further investigation; g) Unless the resident /tenant directs otherwise, notify the victim's responsible party of injuries incurred; h) Notify the victim's attending physician if the allegation could impact the resident's physical or mental well-being: i) Notify the local Police if there is a reasonable suspicion that a crime has Occurred. j) Document all of the above.	F 600		
F 644 SS=B	Coordination of PASARR and Assessments	F 644		

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F 644	Continued From page 9 CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility policy, and staff interview the facility failed to ensure resubmission of the Preadmission Screening and Resident Review (PASARR) following change in medical diagnoses for one of one residents reviewed for PASARR (Resident #39). The facility reported a census of 51 residents. Findings include: The Annual Minimum Data Set (MDS) assessment for Resident #39 dated 4/4/23 revealed the resident scored 11 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated the resident was moderately cognitively impaired. The MDS included a	F 644		

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F 644	Continued From page 10	F 644		

psychotic disorder diagnosis for the resident. The MDS documented that the resident had taken in the last seven days the following medication types; antipsychotic, and antidepressant.

On 4/22/22 a diagnosis of PSYCHOTIC DISORDER WITH DELUSIONS DUE TO KNOWN PHYSIOLOGICAL CONDITION had been added to the resident's medical diagnoses.

The Care Plan, target date 4/11/23, revealed, Resident #39 has a psychosocial well-being problem r/t (related to) Depression and Mood. One of the interventions documented, Observe/document/report PRN (as needed) any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (Extrapyramidal side effects) (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person.

The Level 1 Form Pre-Admission Screening and Resident Review, review date of 03/28/23, documented the resident had no known or suspected mental health diagnosis.

An order dated 4/12/23 documented as follows; Mirtazapine (antidepressant) 15 milligrams by mouth daily at bedtime related to psychotic disorder with delusions due to known physiological condition.

The Medication Administration Record dated 7/1/2023 to 7/31/23 documented the following medication entry; Seroquel 50 milligrams by

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F 644	Continued From page 11 mouth daily for mood distrubance with the start date of 7/12/23. On 7/13/23 9:48 AM the Administrator was queried in which instances a level one assessment would be resubmitted, and explained this would occur if the nurses communicated a significant change or medication change. Diagnoses for Resident #39 and the Level 1 PASARR form were reviewed with the Administrator, who confirmed it should have been resubmitted. Any further PASARR for this resident was requested from the Administrator. On 07/13/23 at 9:48 AM, the Administrator explained there was no other PASARR in the record. The Administrator advised a Level 1 PASARR was submitted to on 7/12/23. The Administrator explained there was a process which the facility had not yet initiated. This process would include any time there was a new diagnosis follow up would occur to see if there was need for a new PASARR. Policy provided by the facility titiled; Change of Status PASRR Level I Submissions, dated 04/2019 documented the following; Anytime a resident with mental illnes or intellectual disabilty or related condition experiences changes which affect his/her placement or service decision the nursing home staff must contact Ascend to report that change (via a new Level I).	F 644		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		

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F 658	Continued From page 12 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review the facility failed to ensure 24 of 24 residents (Resident #104, #105, #106, #107, #108, #109, #110, #111, #112, #54, #39, #14, #22, #113, #20, #15, #5, #31, #17, #114, #18, #115, #13, and #14) were provided with professional standards of nursing care on 7/4/2022 from 2:00 PM to 6:00 AM, by Staff A, Licensed Practical Nurse (LPN) who documented medications were given, but during review of video footage and a facility timeline was found to dispense and dispose of resident medications instead of administering the medications to residents. The facility reported a census of 51 residents. Findings include: Record review of a document created by the facility titled, Medications Documented as Administered by Staff A on 7/4/2022, documented the following 24 residents failed to receive medications on 7/4/22 while Staff A was working: Resident #104, #105, #106, #107, #108, #109, #110, #111, #112, #54, #39, #14, #22, #113, #20, #15, #5, #31, #17, #114, #18, #115, #13, and #14. Record review of an undated document created by the facility titled, Timeline, instructed Staff A's whereabouts during her shift and what she did on 7/4/22 at 2:20 PM to 7/5/22 at 6:00 AM. Through review of the timeline Staff A did not pass medications to residents. Record review of a document submitted to the [state redacted] Board of Nursing regarding Staff	F 658		

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(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 658	Continued From page 13	F 658		

A by the facility instructed the following:
On 7/5/2022 the Administrator received a concern from a night shift employee that Staff A that worked for a local staffing agency was asleep in the recliner during her 2:00 PM to 6:00 AM shift on 7/4/22. After watching the camera footage, Staff A was asleep from 1:48 AM to 3:40 AM. No other nurse was on duty as this time. During investigation, it was identified that Staff A did not complete her medication administrations that she signed off in the Medication Administration Record (MAR) for multiple residents on 7/4/22. It can be seen in the video cameras that within a 15-minute period, Staff A removed the medications which should have been given on her shift for all assigned residents. She removed the medication cards a few at a time, took out the doses scheduled for her shift, and disposed of them. Some of the medications were put into a medical disposable glove and discarded in the trash. It is unclear via the camera if all medications were thrown in the garbage or if medications could have been kept on her person and stolen. The view is blocked by the laptop on the nurse's cart. Staff A also would have taken out her own trash and disposed of it which is not within sight of the camera. The Administrator also documented she talked to Staff A on 7/5/22 at 6:00 PM via phone that she threw away one resident's medications.

During an interview on 7/12/23 at 3:44 PM with the facilities Administrator revealed she received an anonymous note under her door on 7/5/2022 informing her Staff A was sleeping on 7/4/22. She revealed she started to watch the facilities cameras and found there was times she was sitting in the recliner and may have been sleeping. She informed she watched the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165325	A. BUILDING _____ B. WING _____	07/13/2023

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F 658	Continued From page 14	F 658		

medication pass and typed up a timeline (Timeline document) of events of exactly what she did to tray an narrow it down. She then revealed she complied a list of residents that did not receive their medications as ordered (Medications Documented as Administered by Staff A on 7/4/2022). She then informed 24 residents did not receive their medications as ordered on 7/4/22. She revealed Staff A was an agency employee that was terminated immediately after this event, but was at the facility for approximately a year and went through all of the facilities normal orientation training. She informed Staff A was well orientated to the facility. She then informed she is unsure of the reason why Staff A did not provide medications to the residents, she informed Staff A worked two (2) prior days that week and they watched the cameras to see if she provided medications on those days and she did, so unsure of why this occurred, this is not what the facility expects of it's employees.

During an interview on 7/13/23 at 9:48 AM with the Director of Nursing (DON) revealed she would of expected Staff A to pass medications to all residents as they were ordered. She revealed Staff A was well trained and worked at the facility for about a year, she informed she does not know why she did not pass the medications as she was not trained that way.

Record review of the facilites policy titled, Abuse Prevention, Training, and Investigations, last revised on 12/30/20 revealed the facility followed their policy and procedure by completeing the following:
The facility has a comprehensive system of practices and procedures designed to

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F 658	Continued From page 15 a) prevent occurrences of mistreatment, abuse, neglect, and/or misappropriation of resident property, b) monitor, identify and investigate injuries of unknown source and any allegations of suspected abuse, and c) insure that reasonable suspicions are reported to the appropriate law enforcement and regulatory oversight agencies.	F 658		

Manor House Care Center

1212 South Stuart Street • Sigourney, IA 52591 • Ph: (641) 622-2142

Plan of correction related to survey completed July 10-13, 2023.

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited. This plan of correction is prepared solely because it is required under federal or state law.

F000 Correction Date: August 12, 2023

F 600 Free from Abuse, Neglect, and Exploitation: CFR(s): 483.12(a)(1)

1) The administrator responded immediately to a concern of a nurse sleeping reported on 7/5/22 and performed a full investigation. The contracted agency nurse named in the allegation was suspended immediately. The administrator identified through thorough investigation of the allegation that the nurse also did not pass medications during her shift although she had signed them off on the medication administration record. The nurse did not return to the facility.
2) Facility will continue to require all employees, including contract employees, to complete or have a current certificate for dependent adult abuse education through the Iowa Department of Health and Human Services upon hire and a refresher course every 3 years as required. Facility also requires annual education related to abuse identification and prevention through Relias training platform. Completion of required courses tracked by Human Resource Coordinator.
3) Administrator will continue to investigate all allegations of abuse and report them within required time frames to the Department of Inspections and Appeals and local law enforcement.
4) Compliance of dependent adult abuse education and allegations of abuse will be reviewed quarterly during the facilities QAPI meeting.

F 644 Coordination of PASRR and Assessments: CFR(s): 483.20(e)(1)(2)

1) Administrator submitted a new PASRR for resident #39 on 7/12/23. The result was a negative level 1 PASRR, no level 2 or mental health services were recommended for resident #39.
2) Facility will initiate a new level 1 PASRR for any resident with a mental illness or intellectual disability or related condition if they experience changes which affect his/her placement or service decision.
3) Social Worker and Director of Nursing will audit new medications and diagnosis weekly for 4 weeks, then monthly for 3 months, then quarterly for 2 quarters to ensure level 1 PASRR is submitted when indicated.
4) Results of these audits will be reviewed in the facility's quarterly QAPI meetings.

F 658 Services Provided Meet Professional Standards: CFR(s): 483.21(b)(3)(i)

1) The administrator responded immediately on 7/5/22 to a reported concern of a nurse sleeping and performed a full investigation. The contracted agency nurse named in the allegation was immediately suspended. The administrator identified thorough investigation that the nurse failed to pass medications during her shift although she signed them off on the medication administration record. The nurse was never allowed to return to work at the facility. The incident was reported timely to the nurse's employment agency, Department of Inspections and Appeals, law enforcement, and the Iowa Board of Nursing following all regulatory requirements.

2) Director of Nursing will audit medication administration and documentation monthly for 3 months, then quarterly to ensure professional standards are met.

3) Findings of these audits will be reviewed quarterly during the facilities QAPI meeting and through determine need and frequency for continued audits.