STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165174	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa DE Paz Health Care Center	2121 West 19th Street Sioux City, IA 51103

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on video footage review, staff interviews, and facility policy review the facility failed to count 4 of 4 resident's (Resident #1, #2, #3, and #17) narcotics after they were signed for upon delivery from the pharmacy. The facility reported a census of 67 residents. Findings include: Review of the facility's video footage dated 12/26/24 revealed the following: -At 5:59 PM a male pharmacy staff member entered the building and Staff A Registered Nurse (RN) greeted him at the receptionist's desk, located across from the front entrance. Staff A removed pink and white slips out of the red and white bags. Staff A is seen signing the sheets and handing them to the pharmacy staff member, placing the bags to the side. -At 6:02 PM Staff A picked up a black box and left the receptionist's desk. Staff A failed to go through the medication bags to count the medications. A pink document titled Packing Slip, dated 12/26/24 document the following medications were delivered to the facility on [DATE]: -morphine sulfate (treatment of moderate to severe pain) extended release 15 milligrams (mg), 6 tabs for Resident #1, -belbuca (strong pain medicine) 450 micrograms (mcg) file, 14 patches for Resident #2, -hydrocodone (treatment of moderate pain) 5-325mg, 3 tabs for Resident #3, -pregabalin (treatment of nerve and muscle pain) 50mg capsules, 9 tabs for Resident #17. On 1/8/25 at 4:41 PM Staff B stated when pharmacy delivers narcotics, they are to verify what amount was delivered, sign the packing slip and put them away. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 10:52 AM Staff A stated the day the medications were delivered to the facility she acknowledged she pulled all of the papers that had what was delivered in each bag, signed them and gave them to the pharmacy staff member. Staff A and the pharmacy staff member then went to the medication room to restock their omni cell. Staff A indicated she does not normally check in medications when they are delivered, it is usually the overnight nurses that will do it. She acknowledged she should have looked at the medications themselves and compared it to the number on the slips. She added she should have checked all the medications, not just the narcotics. When asked who counted the medications that day, she indicated she was not sure who did. She admitted it was a mistake to not count the medications and she should have counted them. It was an honest mistake and it was definitely a learning lesson. On 1/9/25 at 2:39 PM the Assistant Director of Nursing (ADON) stated when pharmacy makes a medication delivery the staff member checking in the medications should stop everything they are doing to focus on checking in the medications. They are to take one bag at a time, rip open the clear plastic seal on the outside of the bag to get the pink slip out. The pink slip is used when medication being delivered is a narcotic. The staff member will then open the bag, take out the medication, count the number that was dispensed with the pharmacy staff member present to ensure the number delivered matches the quantity on the pink slip. She added the narcotics should be checked and counted before the other medications. The ADON stated when counting in the narcotics, staff will also start a count sheet that needs to filed out that includes the number of narcotics delivered. She added you have to pay attention, you just have to. On 1/9/25 at 4:47 PM the Director of Nursing (DON) stated on 12/26/24 the medications were signed by Staff A but she admitted to not looking at the number of medications delivered to verify what was delivered. She should have laid eyes on the medications before signing for them. When asked why Staff A did not count the narcotics that were delivered she stated Staff A had a busy day and had to change out the medications in their omni cell, it caught her off guard because she never had to do it before. The facility provided a policy titled Controlled Substances, with a revision date of December 2012, that stated the facility shall comply with all laws regulations, and other requirements related to handling, storage, disposal and documentation of scheduled II and other controlled substances. The policy indicated controlled substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals must sign the designated controlled substance record.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074 Based on the observation, video footage review, staff interviews and facility policy review the facility failed to appropriately store the medications of 19 residents after they were signed for upon delivery from the pharmacy. The facility reported a census of 67 residents. Findings include: Review of the facility's video footage dated 12/26/24 revealed the following: -At 5:59 PM a male pharmacy staff member entered the building and Staff A greeted him at the receptionist's desk, located across from the front entrance. Staff A removed pink and white slips out of the red and white bags. Staff A is seen signing the sheets and handing them to the pharmacy staff member, placing the bags to the side. -At 6:02 PM Staff A picks up a black box and leaves the receptionist's desk. -At 6:04 PM three family members stood at the receptionist's desk, where the medication bags were left opened and unsupervised by staff. A fourth family member came to the desk and wrote in the sign in/out binder, within arm's reach of the medication bags. -At 6:05 PM Staff B went to the receptionist's desk to collect the opened medication bags. -At 6:06 PM Staff A and Staff B then go the nurse's station with the opened medication bags. White and pink documents titled Packing Slip, dated 12/26/24 document the following medications were delivered to the facility on [DATE]: -morphine sulfate (treatment of moderate to severe pain) extended release 15 milligrams (mg), 6 tabs for Resident #1 -belbuca (strong pain medicine) 450 micrograms (mcg) file, 14 patches for Resident #2 -hydrocodone (treatment of moderate pain) 5-325mg, 3 tabs for Resident #3 -linzess (treatment of constipation) 72mcg capsules, 30 capsules for Resident #4 -buspirone (treatment of anxiety) 5mg, 60 tablets; furosemide 40mg, 45 tablets; tamsulosin 0.4mg, 60 capsules for Resident #5 -lantus (treatment of diabetes) solostar pen 100unit(U)/milliliter (mL), 6 pens; insulin lispro 100U/mL injection, 10 pens for Resident #6 -farxiga (reduce the risk of worsening kidney disease) 5mg, 14 tablets for Resident #7 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-hydroxyzine (treatment of anxiety) 10mg, 14 tablets for Resident #8 -mirtazapine (treatment of depression) 7.5mg, 30 tablets for Resident #9 -terazonsin (treatment of high blood pressure) 10mg, 60 tablets for Resident #10 -glipizide (treatment of diabetes) extended release 5mg, 30 tablets for Resident #11 -toujeo solostar (treatment of diabetes) 300U/1.5mL, 1.5 for Resident #12 -toujeo solostar 300U/1.5mL, 1.5; Januvia 100mg, 14 tablets for Resident #13 -metoprolol (treatment of high blood pressure) 25mg extended release, 15 tablets; mirtazapine 15mg, 30 tablets for Resident #14 -gabapentin (treatment of seizures and pain) 600mg, 45 tablets for Resident #15 -toujeo solostar 300U/1.5mL, 1.5; metoprolol 25mg extended release, 30 tablets for Resident #16 -pregabalin (treatment of nerve and muscle pain) 50mg capsules, 9 capsules; amlodipine 10mg, 30 tablets for Resident #17 -buspirone 5mg, 90 tablets for Resident #18 -levetiracetam (treatment of seizures) 500mg, 10 tablets for Resident #19 On 1/8/25 at 11:28 AM Staff E Registered Nurse (RN) stated after medications are checked in upon delivery from the pharmacy, the narcotics are to go in the lock box and the other medications go in the medication carts. On 1/8/25 at 11:33 AM Staff C Licensed Practical Nurse (LPN) went to her medication cart, unlocked the cart, obtained a new key, unlocked a lock box within a medication drawer and observed narcotic medications being stored in. On 1/8/25 at 3:36 PM Staff B stated on 12/26/24 she went out to the medication cart and noticed at the receptionist's desk by the front entrance, a lot of opened medication bags unattended. She indicated she saw 2 family members leaning on the desk, another family member signing a book. These family members were within arm's reach of the medication bags. Staff B then went over, grabbed the bags and took them to the nurse's station. She indicated Staff A then walked up to the front and Staff B informed her she moved the bags because there opened and unattended. Staff A let her know she already signed for them. Staff B indicated after medications are checked the narcotics get locked up and the other medications are placed in the appropriate medication cart. On 1/9/25 at 9:05 AM Staff D LPN stated after you sign for the medications they are to put away immediately. She added you drop everything you are doing and put the medications away that were delivered. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/9/25 at 10:52 AM Staff A stated after she signed in the medications on 12/26/24, her and the pharmacy staff member went to the medication room to replenish the omni cell. When she came back up to the front of the building the overnight nurse had the medication bags in her hands, going to the nurse's room. Staff A indicated the medications should have been locked up after they were delivered, not left on unattended. On 1/9/25 at 4:47 PM the Director of Nursing (DON) stated when medications are delivered to the facility they should be taken to the medication carts or put in the overflow cart. The facility provided a policy titled Controlled Substances, with a revision date of December 2012, that stated the facility shall comply with all laws regulations, and other requirements related to handling, storage, disposal and documentation of scheduled II and other controlled substances. The policy indicated controlled substances must be stored in the medication room in a locked container, separate from containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtained medications for residents.