STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on observation, staff, resident and physician interview along with the facility policy/procedure, the facility failed to prevent a significant medication error from occurring. On 9/16/24, during the morning medication pass, a Certified Medication Aide took Resident #1 and Resident #2 oral medications in clear plastic medication cups into the room in one hand and proceeded to sit down Resident #2 medications on the bedside table and then proceeded to go to Resident #1 bedside table and sat them down. Resident #1 received Resident #2 medications for which resulted in Resident #1 becoming lethargic and difficult to arouse during a morning activity. This warranted an intervention from the physician and ultimately Resident #1 was sent to the nearest emergency room and was admitted with adverse effect of drug, hypoglycemia (low blood sugar) and lethargy. Resident #2 had more anxiousness and crying episodes and required monitoring throughout the day. This failure resulted in Immediate Jeopardy to the health, safety, and security of the resident. The facility reported a census of 68 residents. On September 24th, 2024 at 4:15 PM, the Iowa Department of Inspections, Appeals, and Licensing (DIAL) staff contacted the facility staff to notify them the Department staff determined an Immediate Jeopardy (IJ) situation existed at the facility. The facility staff removed the immediacy after the facility staff completed the following: a. Medication Administration Education i. Has Medication Administration Record (MAR) with medication cart ii. Checks medication against MAR for the following iii. Right Medication, Right resident, right route, Right time, Right dose iv. Completes 3 checks against MAR: 1. Before removing form drawer 2. As medication is being removed from card 3. Before returning drug to drawer v. Locks Cart and provides privacy screen to computer (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	vi. Delivers medication to ONE resident and visualizes medication being swallowed vii. Performs hand hygiene viii. Returns to med cart and signs off medications b. The staff will follow the Medication Administration policy, the facility educated the nursing staff who administer medication regarding the policy. i. Medication will be administered to one resident at a time. c. The facility will conduct audits to assure staff perform the medication pass appropriately for 4 Audits per week for 4 weeks, then 2 audits per week for 2 weeks, and then submit the results of the audits to QAPI team for further review. d. The facility educated the nursing staff, who pass residents' medication, regarding medication administration expectations regarding the 5 rights e. Corrective action taken for resident(s) affected: Resident #1 sent to hospital for treatment. i. Risk management completed for Resident #1 and Resident #2. ii. The nursing staff monitored Resident #2 for any changes in condition. The facility implemented their plan of correction and removed the immediacy on 9/19/24 and the scope was lowered from a K to a G. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE], reflected they had no difficulty in making themselves understood or the ability to understand others The MDS identified a Brief Interview for Mental Status of 14, indicating intact cognition. The MDS listed Resident #1 as independent with ambulation with a walker. The MDS included diagnoses of heart failure, hypertension (high blood pressure), asthma and cerebrovascular accident (stroke). Resident #1 received a diuretic (water pill) within the lookback period. The Care Plan Focuses initiated: a. Activities of daily living (ADL's). The Interventions directed: i. She walked independent in her room and in the hallway with her 2 wheeled-walker. ii. She transferred independently. b. Resident #1 had hypertension and utilized Maxzide. Furosemide started 2/22/24. The Interventions directed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	i. Give anti-hypertensive medications as ordered, then monitor for side effects such as orthostatic hypotension (drop in blood pressure with position changes) and increased heart rate (tachycardia). The Clinical Physician orders reviewed 9/1/24, instructed staff to give: *Cardizem LA tablet, (hypertension) extended release 24-hour, 360 milligrams (mg), every morning (am) medication (med) pass for high blood pressure. *Cyanocobalamin tablet (Vitamin B 12) 500 mcg (2) tablets one time a day, every am med pass. *Ferrous Sulfate tablet 325 mg (66 Fe) (iron supplement) one tablet one time a day at am med pass. *Furosemide give 60 mg one time a day for edema, every am med pass. *Imatinib mesylate tablet 100 mg, give 300 mg by mouth one time a day for cancer, every am med pass *Maxzide 25 tablet, 37.5 25 mg (hypertension) give one capsule one time a day am med pass. *Metoprolol Succinate ER, (hypertension) release 24-hour 100 mg give one tablet one time a day at am med pass. *Miralax packet (constipation) 17 grams (gm) give one packet by mouth one time a day, am med pass. *Omeprazole oral capsule, give 40 mg one time a day, for GERD, am med pass. *Vitamin D3 tablet 50 micrograms (mcg), give one tablet one time a day for supplement, am med pass *Magnesium oxide tablet, 400 mg by mouth two times a day for hypomagnesemia, am med pass. *Potassium Chloride ER tablet extended release 10 MEq by mouth two times a day for hypokalemia. *Tylenol Extra Strength Oral tablet 500 mg, give 2 tablet my mouth TID, am med pass, for discomfort. The Medication Error Incident Report dated 9/16/24 at 10:29 AM indicated someone summoned the nurse to the activity room. Upon arriving, the nurse found Resident #1 sitting in chair near window eating a bacon, lettuce, tomato (BLT) sandwich. The staff described her as being very tired and not like herself that day. Resident #2 sitting next to Resident #1 stated she thought she might have received the wrong medications that morning. Resident #1 difficult to arouse and said to the nurse, there are two of you in front of her. Resident #1 unable to grasp and feed herself like she normally would. Resident #1 appeared pale in color. Blood sugar checked: 112. When the nurse spoke with the CMA, they didn't know for sure if they misplaced the medications or not. Resident #1 reported she didn't know, she felt tired, and wanted to know why there was 2 nurses. The nurse assessed Resident #1's vitals, and notified the provider. The provider instructed to check vitals every 30 minutes for 4 hours and if Resident #1 continued to be drowsy or had unstable vitals send to ED after 6 hours of monitoring. Resident brought to nurses' station for monitoring. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Incident, Accident, Unusual Occurrence Note dated 9/16/24 at 11:10 AM, when summoned to the activity room, the nurse found Resident #1 having a BLT as an activity. The staff reported Resident #1 didn't act like herself and appeared very lethargic. After the nurse entered the room, she found Resident #1 difficult to arouse. Resident #2 sat next to Resident #1 and said she thought Resident #1 might have taken the wrong medications on accident. The nurse took Resident #1's vitals at that time and notified the Primary Care Provider (PCP). The PCP instructed to monitor vital signs closely and send to the Emergency Department (ED) if she continued to be lethargic after 6 hours. The Summary for Providers Situation Note dated 9/16/24 at 11:10 AM reflected Resident #1 had an altered mental status (hyper alert, drowsy but easily aroused, difficult to arouse) with the following vital signs: blood pressure: 84/56 (average 120/80), pulse: 80 (average 80-100), pulse oximetry: 98.0 % (average 90-100%) on room air. Resident #1 had a primary diagnosis of cancer. The assessment indicated Resident #1 had general weakness. The PCP directed to monitor vital signs every 30 minutes for 4 hours and send to ED for evaluation if lethargy and weakness continued. The Emergency Medicine Report dated 9/16/24 at 12:36 PM, listed her Chief Complaint as medication administration. The note continued indicating Resident #1 received the wrong medication. Resident #1 mistakenly received her roommates' medications at 8:00 AM, that morning. The medications she received included: Jardiance 25 mg (diabetes medication), Lasix 40 mg (hypertension medication), meloxicam 15 mg (arthritis medication), Protonix 40 mg (stomach protection from acid), metoprolol 50 mg (hypertension medication), Seroquel 50 mg (antipsychotic medication), gabapentin 300 mg (nerve pain medication), Metformin 1000 mg (diabetes medication), lorazepam 1 mg (antianxiety medication), Tizanidine 4 mg (hypertension medication), Glimepiride 3 mg (diabetes medication), and duloxetine 90 mg (antidepressant medication). Resident #1 arrived somnolent (sleepy) but arousable to painful stimuli. She is lethargic (extremely tired), but withdraws to pain. Contacted poison control, listed medications she received, they advised to monitor blood glucose for 24 hours due to intake of glyburide, watch for respiratory depression (decreased breathing), Central Nervous System depression (the brain slows, causing the body to slow heart rate, breathing, and/or a loss of consciousness) due to gabapentin, lorazepam, tizanidine, and duloxetine. They recommended to repeat an EKG (heart monitoring) in 6 to 8 hours. Resident #1 was critically ill and required the provider's constant attention, providing direct management of acute potentially life-threatening situations involving acute impairment or failure of one or more vital organ systems, and/or likelihood of imminent or rapid deterioration. Resident #1 received critical care for a total of 45 minutes independent of time spent in caring for other patients. She mistakenly received her roommates' medications, leading to significant drowsiness. The differential diagnoses included: 1. Medication overdose 2. Drug interaction effects 3. Hypoglycemia. Resident #1 had a risk for adverse effects (negative effects) from the medications she received, including excessive sedation and potential cardiovascular effects due to the incorrect dosage of metoprolol and other medications. Immediate actions included: monitoring vital signs, blood glucose levels, performing an EKG to assess cardiac status, supportive care to manage sedation, and potential adverse effects. The hospital contacted Poison Control for further recommendations. She required observation to ensure her stability and to prevent complications from the medication error. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Acute/Follow Up Note dated 9/16/24 at 2:30 PM reflected the PCP emergently evaluated Resident #1 at the request of nursing staff due to persistent lethargy. The nursing staff reported a staff member incorrectly gave Resident #1 her roommate's medications. The staff reported her in a normal state of health prior to receiving the medications. A few hours afterwards, Resident #1 became lethargic and difficult to arouse. Her initial vital signs assessed within normal limits and she didn't appear in acute distress. Unfortunately, after 30 minutes, she became hypotensive (low blood pressure) and much more difficult to arouse. On medication review, She received: *50 mg of metoprolol, (hypertension) *50 mg of Seroquel, (sedative) *gabapentin 300 mg, (nerve pain) *metformin 1000 mg, (diabetes mellitus) *lorazepam 1 mg, (sedative) *tizanidine 4 mg, (sedative) *glimepiride 3 mg, (diabetes mellitus) *duloxetine 90 mg, (depression, sedative) *Jardiance 25 mg (diabetes mellitus) *furosemide 40 mg. (hypertension) Resident #1 had a blood pressure on recheck of 84/56 and blood glucose within normal limits. Resident #1 transferred to the ER emergently for further evaluation. The PCP couldn't obtain a review of systems due to mental status. The physical Exam revealed Resident #1 as very lethargic and difficult to arouse. Neurological: Lethargic and very difficult to arouse. Diagnoses: Toxic metabolic encephalopathy, hypotension. Plan: Acute toxic metabolic encephalopathy. Received multiple sedating medications including quetiapine, gabapentin, lorazepam and tizanidine. Resident #1 went to the ER for observation in case she needed airway protection. Also, for risk of hypoglycemia due to receiving antidiabetic medications, Jardiance and glimepiride. Resident #2's MDS assessment dated [DATE], reflected she had no difficulty in making herself understood or the ability to understand others. The MDS identified a BIMS score of 15, indicating no cognitive impairment. The MDS listed Resident #2 as independent with ambulation with a wheelchair. The MDS included diagnoses of hypertension, gastroesophageal reflux disease (GERD), diabetes mellitus, anxiety, and depression. Resident #2 received antipsychotics, antianxiety, antidepressant, and hypoglycemic medications in the lookback period. The Care Plan Focuses reflected the following: a. Initiated 11/3/23: Resident #2 received anti-anxiety medications related to anxiety. The Interventions directed: i. Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift. ii. Monitor for side effects (Sedation, Lethargy, Dry Mouth, Constipation, Diarrhea, Blurred Vision, Tardive Dyskinesia, Orthostatic Hypotension, Nausea and Insomnia) and effectiveness. iii. This medication has a black box warning b. Revised: Resident #2 used antidepressant medication related to depression and insomnia. The Interventions instructed the following: i. Administer antidepressant medication as ordered by physician. Monitor and document side effects and effectiveness every shift. ii. Monitor behaviors such as: crying, insomnia, and anger (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c. Resident #2 used antipsychotic medications related to anxiety and depression. The Interventions directed the following: i. Administer antipsychotic medications as ordered by physician. ii. Attempt one or several of the following as allows: 1:1, Talk in a calm voice, Music Therapy: iii. Ask what kind of music he/she likes and play on cell phone if able. Walk around facility or take wheelchair ride. Show activities in a little box of calm, offer food, and/or drink d. Resident #2 used insulin and hypoglycemic medications related to diabetes. The Interventions instructed the following: i. Administer insulin medications as ordered by physician. ii. Resident #2 had diabetes. iii. Monitor blood glucose as ordered. iv. Monitor for side effects (low blood sugar, headache, weakness, sweating and fainting) and effectiveness. The Focused Evaluation Note dated 9/16/24 at 12:20 PM listed the reason for evaluation as Resident #2 had a possible medication error. The assessment reflected normal vitals her. She reported having some facial flushing and anxiety. The Focused Evaluation Note dated 9/17/24 at 7:33 AM indicated the reason for evaluation as Resident #2 had a medication error. She reported a headache that morning. The Incident, Accident, Unusual/ Occurrence Note dated 9/17/24 at 11:02 AM indicated Resident #2 reported she received a green pill during the AM medication pass on 9/16/24 that she never took before. With her morning meds, she received a green pill, and she didn't take a green pill. The nurse observed the morning medication bubble packs and noted two bubble packs with light green colored pills prescribed to Resident #2 that matched orders on the Medication Administration Record (MAR). The nurse took the bubble packs Resident #2's room to show her. She explained she didn't take those medications, she took a green capsule. The nurse notified the on-site provider of report from Resident #2. The Medication Error Form dated 9/16/24 at 8:18 AM, indicated Resident #2 reported on 9/17/24 she received a green pill during the AM medication pass on 9/16/24 that she never took before. Resident #2 reported she received a green pill during the AM medication pass on 9/16/24 that she never took before. With her morning meds, she received a green pill, and she didn't take a green pill. The nurse observed the morning medication bubble packs and noted two bubble packs with light green colored pills prescribed to Resident #2 that matched orders on the Medication Administration Record (MAR). The nurse took the bubble packs Resident #2's room to show her. She explained she didn't take those medications, she took a green capsule. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 9/24/24 at 9:04 AM, Resident #2 stated on 9/16/24 around 8:30 AM, Staff B, CMA, came into her with two plastic clear medication cups in one hand. Staff B, set down one medication cup on her over bedside table and then went to Resident #1. Resident #2 stated she swallowed the medications in the medication cup without looking at them. Resident #1 asked Staff B, if the medication cup had her cancer medications in it, as she couldn't identify the medications in the cup. Staff B, replied the medication cup had metformin and diabetes medications. Resident #1 said she didn't take any medications for diabetes, Staff B, responded, those are your ordered medications and left the room. Staff B came back in and said here are your cancer medications, then left again. Resident #1 and Resident #2 went to the activity room to enjoy BLT sandwiches. Resident #1 sat across from Resident #2 in a regular chair. She described Resident #1 as alert and oriented, the she started to get really sleepy and tired. Resident #2 stated she started to cry and was felt anxious all day long. When Resident #2 took the right medications, she reported being calm, no crying and felt really good. On 9/16/24, she described herself, as not like herself. She described herself as more anxious, tearful, sad, and felt down. Interview on 9/23/23 at 3:30 PM, Staff A, Licensed Practical Nurse (LPN), stated that on 9/16/24 around 11:00 AM, the activity staff came and said Resident #1 didn't act right in the activity room. Staff A went to the activity room, and found Resident #1 pale, lethargic, and not acting right. Staff A described Resident #1 earlier that afternoon as alert and happy. Staff A explained when they went into the activity room, they discovered Resident #1 leaning on the table and unable to lift a sandwich to her lips to eat. Staff A asked Resident #1 if she knew who they were, Resident #1 responded yes, but she saw two of her. Resident #2 reported Resident #1 may have received Resident #2 meds instead of her own. Staff A explained she got really concerned knowing Resident #2 got diabetes and depression medication. The facility physician was at the facility so Staff A, proceeded to get them. They completed an assessment on Resident #1 and gave orders while in the activity room. Staff A said no sooner than they left the activity room to chart, the activity staff brought Resident #1 out of the activity room and made a comment of Resident #1 not doing well. They positioned Resident #1 in front of the north nurses' station, Staff A confirmed Resident #1 didn't look good and called 911. Staff A questioned Staff B related to what Resident #2 told Staff A. Staff B, stated they had both Resident #1 and Resident #2 meds in a plastic med cup in one hand and took the medications into their room. They sat a med cup on the bedside table by each resident, Staff B couldn't for sure say each resident got their right medications. Staff A said they counseled Staff B on the proper medication pass. Staff A told Staff B to give one resident their meds, then go and do the other resident's med. She added to not to take two meds in at the same time. Staff A, stated that the proper procedure is to follow the medication administration policy, to do the 6 rights and only do one resident at a time, not two at once. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 9/24/24 at 9:30 AM, Staff D, Activity Assistant described Resident #1 as happy, alert, oriented, and able to converse with the other resident in the activity room. Staff B stated they looked over at Resident #1 and noted her falling asleep at the table. When Staff D, asked Resident #1 if they were ok, she replied yes, she was just really tired, sleepy, and she couldn't stay awake. Staff D described this as unusual for Resident #1, as she was always awake during activities and never slept through them. Around 10:15 AM 10:30 AM, as Resident #1 started to eat her BLT and she kept leaning to the right on the table, slowly dozing off. Staff D went and got the nurse. Staff D did an assessment on Resident #1 and left the activity room. Staff D kept a close eye on Resident #1 and finally said something is not right, so she found a staff member to help her transfer a very lethargic and sleepy Resident #1 from the chair to the wheelchair. Staff D stated when they got back to the activity room, Resident #2 said she hoped Resident #1 didn't get her medications, as the CMA came in with both med cups in one hand and set one down on her bedside table and one on the other bedside table. Interview on 9/24/24 at 8:10 AM, Staff C, CMA, confirmed the expectation is to give one resident their medications at a time and to follow the 5 rights for medication administration according to the policy/procedures. Interview on 9/24/24 at 11:00 AM, Staff E, CMA, verified the expectation is to give one resident their medications at a time and to follow the 5 rights for medication administration according to the facility policy/procedures. Interview on 9/25/24 at 9:15 AM, Resident #3 and Resident #4, stated that it is very common for Staff B to bring in their medications in one hand and then set one plastic medication cup on one bedside table, go to the other and set their medications down on their bedside table, then leave the room. Interview on 9/25/24 at 2:00 PM, Resident #5, stated that Staff B would come into her room and sometimes would have two clear plastic medication cups in one hand and leave one on her bedside table and then take the other one to her roommate. Interview on 9/25/24 at 4:00 PM, the Director Of Nursing confirmed they expected the nursing staff to follow the physician's orders as written. The Administrating Oral Medications Policy/Procedure dated October 2010, instructed to provide guidelines for the safe administration of oral medications by: a. Verify that they have a physician's medication order. b. Review the resident's care plan to assess if they have any special needs c. Assemble the equipment and supplies as needed. The steps included to check the label on the medication, confirm the medication name, and dose with the MAR. Check and re-check the medication to confirm the proper dose. Confirm the identity of the resident. Place medications on the bedside table or tray and remain with the resident until they took all of their medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Documentation of Medication Administration Policy/Procedure dated April 2007, had a policy statement that the facility shall maintain a medication administration record to document all medications administered. The policy instructed administering of medication must be documented immediately after (never before) it is given. An In Service Form dated 9/19/24, regarding Medication Administration directed to deliver medication to ONE resident and visualize them swallowing the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on clinical record review, staff interview, and facility policy/procedure review at the time of the investigation, the facility failed to provide needed services in accordance with professional standards for 1 of 4 residents reviewed for assessment and intervention (Resident #11). The facility identified a census of 68 residents. Findings include: Resident #11's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS listed Resident #11 as independent in the facility with activities of daily living. The MDS included diagnoses of hypertension (high blood pressure), anemia (low blood volume), cerebral palsy (brain damage before birth that causes a movement disorder), asthma, and chronic pulmonary edema (long-term swelling in the lungs. Resident #11 required continuous oxygen during the lookback period. The Care Plan Focuses reflected the following: a. 5/14/24: Resident #11 had hypertension. The Interventions directed the following: i. He wore tension/compression wraps every day. ii. Avoid taking his blood pressure reading after physical activity or emotion distress. iii. Give him anti-hypertensive medications as ordered. Monitor me for side effects such as orthostatic hypotension and increased heart rate (Tachycardia) and effectiveness. iv. Monitor for and document abnormalities. Report significant changes to the physician. v. Monitor him for and document any edema. Notify the physician. b. 2/21/24: Resident #11 received diuretic therapy related to pulmonary edema and hypertension. In addition, Resident #11 had lower extremity edema, that he used a sequential compression pump (air bags wrapped around legs to increase circulation) once a day on both legs. The Interventions instructed the following: i. Administer diuretic medications as ordered by physician. ii. Monitor for side effects (low sodium levels, headaches, dizziness, thirst, muscle cramps and low potassium) and effectiveness. iii. Report pertinent lab results to physician (especially HCT, Na+, K+). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Resident #11 used oxygen therapy related to respiratory illness, he had low oxygen saturation levels. Resident #11 had diagnoses of pulmonary edema and asthma. The Interventions directed the following: i. Administer my oxygen as ordered. ii. Keep the head of the bed (HOB) elevated due to shortness of breath. Resident #11 could control how high he wanted the bed. iii. Oxygen settings: Oxygen via Nasal Cannula (NC) at 5 liters (L) continuously. The Nurses Note dated 9/22/24 at 10:09 PM, documented the nurse called the emergency room (ER) due to Resident #11 transferred to hospital for COPD (chronic lung disease), exacerbation (worsening of symptoms), pneumonia and hypoxia (low blood oxygen levels). The Nurses Note dated 9/23/24 at 6:05 PM, reflected the hospital called to let the facility know Resident #11 passed away. The Nurses Note dated 9/26/24 at 12:34 AM, indicated the documentation didn't save for the day of 9/22/24. During lunch, as the nurse gave insulin to other residents, Resident #11 appeared drowsy and lethargic. When asked if they were okay, Resident #11 nodded and said yes. The nurse found the oxygen tank almost empty. They went to get a new tank and changed it in there in the dining room. Around 9:10 AM when the nurse went into Resident #11's room to flush his suprapubic catheter, measure oxygen, and put his leg sleeves on for his sequential compression pumps on, during interaction resident appeared sleepy but responded to questions. Resident went on with his day and around 3:00 PM, while near the nursing station a certified medication aide (CMA) gave him his medications. The CMA went to the nurse and reported Resident #11 had their left hand swollen. When asked if it hurt, he said no. Resident #11 sat in a chair on the other side of the nursing station sleeping and appeared lethargic. When the nurse assessed Resident #11, he had clear lung sounds, he complained of some shortness of breath, he had his left hand and arm swollen. The assessment revealed no redness to left hand, lips purple in color, skin pale, and intact. When the nurse took vital signs, they immediately changed the NC to a mask and increased oxygen from 6 L to 8 L, oxygen level remained 92%. The nurse called the on-call nurse practitioner (NP), who knew about Resident #11's situation. The NP asked if the nurse thought they should send him out. The nurse replied yes, this is not usual for him. The NP stated to go ahead and send him out. She added, if they needed anything they could call back. The nurse made Resident #11 aware and he agreed to go to the ER. The nurse called 911. When the emergency medical technicians (EMT) go Resident #11's oxygen reading of 97%, they questioned why they were sending him out. The nurse responded Resident #11 didn't act normal, and he had a change. The EMTs took Resident #11 around 5:00 PM to the ER. Interview on 9/25/24 at 5:15 PM, the facility Assistant Director of Nursing (ADON) confirmed the clinical record lacked documentation of an on going assessment with Resident #11's change in condition. The ADON expected the nurses to follow the federal rules and guidelines with documentation, along with the facility policy and procedure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165209	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Specialty Care	309 West Merle Hibbs Boulevard Marshalltown, IA 50158

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Charting and Documentation policy dated, July 2017, directed to provide all services to the resident, progress toward the Care Plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The following information is to be documented in the resident medical record: a. Objective observations b. Changes in the resident's condition