STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165556	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnycrest Manor	2375 Roosevelt Street Dubuque, IA 52001

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on record review, interviews, and policy review the facility failed to review and revise a resident's Care Plan for 1 of 5 residents reviewed for unnecessary medications (Resident #63). The resident's Care Plan did not include focus areas, goals, or interventions for the use of medications for mental health. The facility reported a census of 73 residents. Findings include: The Minimum Data Set (MDS) for Resident #63, dated 01/22/25, documented a Brief Interview for Mental Status score of 14/15 which indicated intact cognition. Diagnoses included anxiety disorder, depression, and schizophrenia. The resident's medication administration record listed the following medications: Divalproex Sodium ER Extended Release 500 MG for schizoaffective bipolar type Invega Sustenna Intramuscular Suspension 234 MG/1.5 ML for schizoaffective bipolar type Lithium Carbonate ER Extended Release 300 MG for schizoaffective bipolar type Quetiapine Fumarate 50 MG for schizoaffective disorder bipolar type Vortioxetine HBr 20 MG for depression During an interview on 02/24/25 at 11:25 AM Resident #63, when asked about a visible tremor, stated it might be from his medication. He reported someone 'checked on it.' A document titled AIMS-Abnormal Involuntary Movement Scale dated 2/4/25 documented movements of the right hand and mouth that affected eating and kept him up at night. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #63's Care Plan, admitted [DATE], documented a mood focus area with interventions to monitor for worsening mood and involve psychiatry, the resident's personal care physician, or pharmacy as needed. Another focus area for PASRR services included general medication management by a psychiatric provider. Neither section addressed the resident's diagnoses of schizophrenia, anxiety, or depression. The Care Plan did not address the resident's current psychotropic medications or monitoring for side effects such as involuntary movement. During an interview with Staff D, Registered Nurse on 02/26/25 at 11:32 AM she indicated nurses, the MDS Coordinator, and the Social Worker could update the Care Plan. On 02/26/25 at 01:17 PM the Social Worker stated she entered information into the Care Plan from the PASRR and specific to triggers and symptoms in the quality of life section. Nursing would enter information regarding diagnoses and medications. On 02/26/25 at 01:42 PM Staff E, MDS Coordinator stated it was her responsibility to enter the psychotropic medications into the Care Plan. After a review of this resident's Care Plan, she confirmed the information was not there and would normally be found under the mood heading. She stated she must have missed it and would work to get that fixed. An undated policy titled Comprehensive Care Plan documented the interdisciplinary team would continue to develop the Care Plan in conjunction with the RAI (Resident Assessment Instrument) and would be ongoing. The Care Plan would address resident goals, actual and potential problems, needs, strengths, and individual preferences and each discipline was responsible for initiation and ongoing follow up as related to their area of expertise.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 37072 Based on observation, staff interview, and record review the facility failed to use proper technique to administer insulin for 1 out of 1 residents injected with an insulin pen (Resident #18). The facility identified a census of 73 residents. Findings include: Review of Resident #18 Medication administration record for February 2025 revealed an order for Fiasp FlexTouch Subcutaneous Solution Pen-injector 100 unit/milliliter inject 26 unit subcutaneously before meals related to type 2 diabetes mellitus. She also had an order for sliding scale insulin. If blood sugar 150-200 inject 3 units Fiasp FlexTouch Subcutaneous Solution Pen-injector. Observation on 2/25/25 at 11:01 AM Staff A, Licensed Practical Nurse (LPN) obtained a blood sugar of 186 for Resident # 18. Staff A dialed up 19 units of Fiasp insulin for Resident #18 and failed to waste 2 units to prime the needle. Staff A needed a second pen to administer the prescribed dose of 29 units. Staff A obtained a second insulin pen and dialed up 10 units of Fiasp insulin. Staff A entered Resident #18 room and administered both pens with insulin. Staff A failed to waste 2 units of insulin to ensure insulin pen functioned correctly on both syringes. On 02/27/25 at 08:17 AM Staff H, Registered Nurse (RN) stated with an insulin pen make sure it is the right person and check your dates. I dial it to 4 units or what the orders is after putting the needle on the insulin pen. I have never heard to waste 2 units before drawing the correct dose in an insulin pen. I was not aware to waste 2 units before administering insulin from a pen. On 02/27/25 08:29 AM Staff I, RN stated when administering insulin from a pen you need to prime the pen with about 5 units of medication and then push it out. This way when you give insulin the next time it for sure will administer the insulin. On 02/27/25 at 10:43 AM the Co Director of Nursing (DON) stated they would have to refer to manufacture instruction for correct procedure and they would expect nurses to follow the manufacture recommendations. The package insert for Fiasp Insulin Flex Touch Pen directed to turn the dose selector to 2 units, then hold the pen with the needle pointing up. Tap the top of the pen gently to let any air bubbles rise to the top. Hold the pen with needle pointing up and hold in the dose button until the dose counter shows 0. A drop of insulin should be seen at the tip.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on observation, kitchen record review, staff interview, and policy review the facility failed to store foods according to professional standards and maintain effective sanitizing solution during 4 of 4 kitchen and 2nd floor dining room observations. The facility reported a census of 73 residents. Findings include: 1. On [DATE] between 9:56 AM and 10:27 AM the initial kitchen observation revealed the following: a. Staff B, [NAME] was observed cleaning the sink with a damp, white rag. There were no filled sanitizer buckets visible. Staff B used the same rag to wipe out the sink and 2 food prep areas. The prep counter in the center of the kitchen and the sink contained food particles and splashes of unidentified light brown and off white liquids. b. A walk in cooler, with a temperature of 22 degrees, contained a cart of milk and a cart of juice. The drinks remained in pans of ice used to keep them cold when transported through the building. 6 jugs of milk were open and undated. The milk was frozen to the sides of the container and lumpy. 6 containers of lemonade and juice did not have preparation or open dates. The tops of the carts contained spilled liquids. A milk crate contained 2 gallons of milk with an expiration date the day before. The cooler also held a box of raisins with no open date, the plastic inside open, and the raisins inside exposed to air. c. A temperature log posted on a refrigerator door, dated for February 2025, contained refrigerator and freezer temperature checks from [DATE] through [DATE]. Temperatures were not monitored between [DATE] and the initial kitchen observation, [DATE]. d. A second walk in cooler in the back corner of the kitchen, with a temperature of 37 degrees, contained two open packages of Swiss cheese that did not have open dates. One of the bags was open and the cheese exposed to air. The other was upside down in a plastic bag labeled green beans. A pound of butter was unwrapped and exposed to air. A container of liquid eggs was open, undated, and the liquid exposed to air. A bag of carrots was open and undated. e. The dry storage area contained mesquite herb seasoning that was dated [DATE], open undated chicken gravy mix, and bulk containers of Caesar dressing with dusty lids and caved in sides dated [DATE]. The can shelves contained dented cans of cream of chicken soup and refried beans. The facility stored a cereal dispenser in the dry storage room that contained frosted flakes, fruit loops, and cinnamon cereal without open dates. f. A large vent on the wall in the dry storage area was coated in a fluffy grey, brown substance. Two carts sat underneath the vent. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:38 AM Staff F, [NAME] and Staff C, Food Service Worker were unable to locate the dishwasher temperature logs or the sanitizer bucket logs. Staff F stated they might be in the Certified Dietary Manager's (CDM) office. Staff F stated when he was in the kitchen he checked temperatures for the dishwasher. On [DATE] at 10:59 AM the CDM provided dishwasher logs. He did not provide logs for the sanitizer bucket chemical checks. He stated he expected staff to take drinks out of the ice in the coolers, wipe down the carts, and dump the ice. He confirmed he was aware the vent in dry storage was dirty and requested it be cleaned by maintenance. He stated some things had gone by the wayside but the facility had a new maintenance director who would take care of it. He also stated they would need to come up with a different plan for dating items when they were opened. He expected the person who opened it to date it. 2. On [DATE] at 11:51 AM the surveyor noted the refrigerator in the dining area of the 2nd floor did not have a temperature log. The thermometer inside was on the top shelf and read 56 degrees Fahrenheit. An additional observation on [DATE] at 11:07 AM revealed the temperature in the refrigerator was 44 degrees, and the thermometer was located in the door. A certified nursing assistants (CNA) assisting in the dining room did not know where to find the temperature log. During an interview on [DATE] at 11:11 AM Staff G, Licensed Practical Nurse (LPN) stated he thought 3rd shift was responsible for monitoring the temperatures and indicated there was a log on the refrigerator behind the nurses station. That log did not include the smaller refrigerator. On [DATE] at 11:18 AM the CDM stated the CNAs were responsible for monitoring the refrigerator temperatures on the units, or maybe environmental services. An additional interview with Staff D, Infection Control Nurse on [DATE] at 11:23 AM determined she was also unable to find a temperature log for the dining room refrigerator, 3. During observations on [DATE] at 10:10 AM and on [DATE] at 3:33 PM the dry storage room revealed the vent was still covered in the fuzzy grey/brown matter. During the [DATE] observation one cart was parked under the vent. At the [DATE] observation two carts were under the vent. On [DATE] at 10:22 AM an observation in the kitchen determined the vent remained coated in a fluffy grey, brown substance. The CDM stated again it was a priority for maintenance but could not tell me when it would be cleaned. During an interview on [DATE] at 11:40 AM the Maintenance Director explained the facility had a new system that allowed work orders to be prioritized based on risk, need, and safety. He confirmed the vent had been cleaned that day. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. A final kitchen observation on [DATE] at 10:22 AM revealed a carton of milk in the walk in cooler without an open date. The CDM stated the milk was from that day and took out a sharpie to label it. When asked again about the logs for sanitizer buckets, the CDM stated they did not have any test strips for the sanitizer buckets and had put a rush order on them. He took ,d+[DATE] papers from a plastic sleeve hanging by the sink that contained incomplete documentation and confirmed they had not been testing to see if the amount of chemical in the buckets was effective. A policy titled Food Storage, undated, indicated open packages of dry storage food should be labeled, dated, and stored in closed containers. Expired foods should be discarded. It further documented thermometers should be placed in every refrigeration and freezer unit, and temperatures should be recorded on the Fridge/Freezer Temperature Log daily, and perishables such as salads, puddings, milk, etc. should be stored in the refrigerator and covered, labeled, and dated until used.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48452 Based on CMS (Centers for Medicare and Medicaid Services) Statements of Deficiencies, the facility Quality Assessment and Performance Improvement (QAPI) Plan, and staff interviews the facility failed to fully implement Quality Assurance (QA) activities to ensure kitchen related deficiencies were corrected and to prevent repeat occurrences. The facility reported a census of 73 residents. Findings include: Form CMS-2567, with a correction date of [DATE], included tag F812 and documented in part that the facility failed to date open foods. Form CMS-2567, with a correction date of [DATE], included tag F812 and documented in part that the facility failed to meet professional standards of food service safety and food had not been prepared under sanitary conditions. The current survey, conducted between [DATE] and [DATE], revealed concerns in the same areas including in part undated open foods, not monitoring refrigerator and freezer temperatures, not monitoring sanitizer chemical levels, dented cans, expired food, and a dusty vent. The facility QAPI Plan titled Facility Assessment and reviewed ,d+[DATE] documented information from the Facility Assessment was used to inform the QAPI process and the description of care, services, and resources provided both areas for monitoring of processes and outcomes as well as information for investigation of root causes of adverse events and gaps in performance. The section titled Policy and Procedure for Quality Assurance Performance Improvement indicated QAPI was integrated into responsibilities and accountability of top management, with the QAPI steering committee setting SMART goals each year reported on monthly. On [DATE] at 10:59 AM the Certified Dietary Manager (CDM) reported that he was working on a goal for a new ticketing system for meal service in the dining room. When asked about the concerns observed in the kitchen, he reported they did audits. During an interview on [DATE] at 11:52 AM the Administrator explained the QAPI committee met every two months. Residents, family members, staff, and departments heads could share concerns with the committee verbally, through resident council meetings, or in writing. All department heads were expected to set SMART goals that would be followed for at least a year. Safety, resident needs, and deficiencies from surveys were considered priority. The Administrator indicated the current dietary SMART goal was related to a dietary ticket system that would help with budgeting, ordering, and more accurately representing resident food needs. She reported the CDM provided audits every QA meeting and issues were immediately fixed with corrective actions. When asked about prior survey concerns in the kitchen, the Administrator stated she understood why there was a QAPI concern and the committee had been trying hard. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:11 PM the CDM provided a document titled 2024 deficiency audits with tabs for food temperature, hairnets, glove usage, date marking, and portion size. In the date marking tab, 13 of 44 entries indicated food was not labeled properly. The audits did not include education provided to staff regarding results.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37072 Based on observation, staff interview, and record review the facility failed to provide proper hand washing and wound care to prevent the spread of infection in 1 out of 1 wound care observed (Resident #34). The facility identified a census of 73 residents. Findings include: Review of Resident #34 physician visit/consult form dated 11/14/24 revealed the resident had a left heel blister drained on 10/29/24 and indicated the area positive for Methicillin-resistant Staphylococcus aureus (MRSA) bacteria. Review of the Care Plan for Resident #34 with a revision date of 12/17/24 revealed an open area to right great toe and left heel. The Care Plan revealed resident had an active infection to left heel and left lower extremity cellulitis. The Care Plan directed staff during active infection institute CONTACT ISOLATION: Wear gowns when changing contaminated linens and prior to entering residents room, gowns and gloves should be removed prior to exiting the room, staff should use good hand-washing before entering and prior to exiting room. Place soiled linens in bags prior to exiting room and place in proper laundry bins . Bag linens and close bag tightly before taking to laundry. Observation on 02/25/25 at 10:37 AM, Staff A, Licensed Practical Nurse (LPN) provided wound care to Resident # 34. Staff provided a dressing change to the left heel and right great toe to Resident #34. Staff donned personal protective equipment (PPE) and stated he washed hands prior to me coming to the room. Staff A double gloved both hands, removed soiled dressing from right great toe and then from the left heel. He did not wash hands or change gloves after removed dressings. He then proceeded to cleanse the wound on left heel and then right great toe wound with soap and water, rinsed each area and then dried first the left heel and then the right great toe. Staff A did not remove gloves or wash hands between the wounds. Staff A removed outer gloves and donned another pair of gloves and then provided treatment to both wounds without changing gloves or washing hands between the wounds. After the treatment completed he removed gloves, cleaned up supplies, removed trash from room and took to utility room next door to residents room and disposed of trash and removed personal protective equipment. Staff A did not wash hands, he returned betadine to medication room on the unit touching medication cart, door knobs and then came out and washed hands. During an interview on 02/27/25 at 08:10 AM Staff H, Registered Nurse (RN) states I would take care of one wound at a time. First wash hands and don gloves, then cleanse wound and again wash hands and don clean gloves. Complete the treatment and then remove gloves and wash hands again. I would then take my gloves off and wash my hands and then go to the next wound and complete one wound at a time and complete the wound care the same way. I would wash my hands before leaving the room. You should not leave the room with gloves on hands. On 02/27/25 at 8:30 AM Staff I, RN stated to keep wounds separate when providing a treatment. You should not go between wounds. I would wash my hands between steps of wound care and changes my gloves. Before you leave the room put the bed down, place call light in reach, and remove gloves and wash your hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/27/25 at 10:26 AM the Infection Preventionist stated if staff are providing wound cares they need to change gloves and wash hands before treating wounds, should only complete wound care on one wound at a time or you risk spreading infection from one wound to another. Staff should use barriers making sure area is clean, between cleansing the wound and removal of the dirty dressing staff should take off gloves and complete hand hygiene. Staff definitely need to use personal protective equipment and change gloves between wounds. Staff should never come out of the room with gloves on and should be completing hand hygiene. Staff should dispose of PPE in the room and hand hygiene in the room not after you have left the room. On 02/27/25 at 10:37 AM the Co Director of Nursing (Co DON) stated the expectation of staff would be they should do one extremity when providing wound care. They should remove dressing, wash hands and don new gloves then do the treatment and complete hand hygiene. Staff should complete one wound before starting another. They should take off their gloves and complete hand-washing before leaving the room. The facility provided a policy titled Hand Washing reviewed 2024 which directed staff hand hygiene would be required before and after changing a dressing. The policy revealed hand hygiene continues to be the primary means of preventing transmission of infections.