

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: #5560	Fine amount reduced by 35% to \$3,250 on pursuant to Iowa Code Section 135C.43A	Date: January 31, 2022
Facility Name: Pillar of Cedar Valley	Survey Dates: December 15, 2021 to January 6, 2022	
Facility Address/City/State/Zip: 1410 West Dunkerton Road Waterloo, IA 50703	GP, SS, TAG, VW	
Rule or Code Section	Nature of Violation	Class
		Fine Amount
		Correction date

58.19(1)n(1)	<p>481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:</p> <p>58.19(1) Activities of daily living. <i>n.</i> Nutrition and meal service. (1) Regular, therapeutic, modified diets, and snacks; (I, II, III)</p> <p>DESCRIPTION:</p> <p>Based on clinical record review, observations and staff and resident interviews, facility staff failed to provide the breakfast meal, failed to always provide interventions to promote nutrition and failed to monitor food consumption for 3 of 3 residents sampled with known weight loss and weight loss interventions in place (Residents #4, #8 and #9). The facility reported a census of 131.</p>	CLASS I	\$5,000 (COLLECT)	UPON RECEIPT
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Facility Administrator

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	<p>Findings Include:</p> <p>1. According to the Minimum Data Set (MDS) assessment dated 11/15/21, Resident #4 had diagnoses which included late onset Alzheimer's disease, major depressive disorder and dementia with behaviors. The resident required the assistance of 1 staff for transfers, walking, dressing, personal hygiene and bathing. Resident #4 utilized a walker to move about the facility. The assessment documented the resident with severe cognitive and memory impairment, as evidenced by a Brief Interview for Mental Status (BIMS) score of zero. The resident required supervision with eating.</p> <p>Review of the resident's Care Plan, revised on 12/2/21, revealed the resident with a problem of low body weight related to limited oral intake due to Alzheimer's disease. The resident could feed herself after she received set-up assistance and required cueing from the staff during meals to promote her intake. The Care Plan instructed staff to encourage the resident to accept the ordered supplement and nutrition related medications to maintain an adequate micronutrient intake. The Care Plan also directed staff to monitor the resident's weight and oral intake as ordered by her physician.</p>				
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	<p>Observation on 12/27/21 at 9:55 a.m. revealed Resident #4 lying in bed, appearing to be asleep. Staff A, CNA (Certified Nursing Assistant) entered the room. Staff a stated it looked like Resident #4 had not been up yet this morning. Staff A stated the resident did not receive breakfast this morning.</p> <p>Review of Resident #4's weight history revealed the following weight measurements:</p> <ul style="list-style-type: none"> a. On 6/8/21 the resident weighed 119 pounds. b. On 7/27/21 the resident weighed 111 pounds. c. On 8/17/21 the resident weighed 117 pounds. d. On 9/1/21 the resident weighed 119.5 pounds. e. On 10/5/21 the resident weighed 121 pounds. f. On 11/2/21 the resident weighed 123 pounds. g. On 12/17/21 the resident weighed 118 pounds. <p>Review of a Nutrition/Dietary Note dated 11/26/21 revealed the resident's weight as under her ideal body weight of 123 pounds and she had a 2.5% weight loss in the last month. The Dietician recommended to offer the resident 8 ounces of Ensure (a nutritional supplement) twice daily, to continue to provide meal set up and monitor her oral intake.</p> <p>Review of the Meal Consumption Report dated</p>			
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	<p>12/17/21 - 1/4/22 revealed the staff failed to document meal consumption for 43 out of 60 meals.</p> <p>Review of the Diet Type Report dated 12/15/21 revealed Resident #4 had a regular consistency diet with a house supplement of 4 ounces of Might Shake daily.</p> <p>2. The MDS assessment dated 9/6/21 documented Resident's #8 had diagnoses which included viral hepatitis, dementia, Parkinson's disease, anxiety and depression. The resident had a BIMS score of 7 which indicated severe memory and cognitive impairment. The resident required limited assistance of 1 staff for transfers, ambulation, dressing and hygiene. The resident required supervision during meals.</p> <p>The resident's Care Plan, revised on 12/8/21, indicated she had an unintended weight loss related to poor appetite as evidenced by meal refusals, trouble swallowing, dementia and a Parkinson's disease diagnosis. The resident required a mechanically altered diet. The Care Plan directed staff to supervise the resident during meals for safety, utilize a lipped plate to promote independence, encourage whole milk at meals, offer a mechanically altered diet as order and to monitor for swallowing problems. The Care Plan also directed staff to offer a</p>			
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	<p>snack at bedtime, to encourage the resident to consume supplements as ordered and honor her food preferences.</p> <p>Review of the Meal Consumption Report dated 12/17/21 - 1/4/22 revealed the staff failed to document meal consumption for 48 out of 60 meals and during 8 of those meals, the resident consumed less than 25% of her meals.</p> <p>Observation on 12/27/21 at 11:09 a.m. revealed Resident #8 lying in bed with her night clothes on. Staff B, RN (Registered Nurse) and Co-Director of Nurses asked the resident if she had been up yet this morning. Resident #8 replied no but she would like to get up and get dressed. The resident stated she has not had breakfast yet that day.</p> <p>Review of the Physician's Order sheet failed to indicate the resident had an order for additional nutritional supplements until 12/27/21.</p> <p>Review of a Diet Type Report dated 12/15/21 indicated Resident #8 ordered to have a pureed, regular fluid consistency, no added salt diet. The report did not record the resident should have whole milk at meals, that she consumed a supplement or</p>			
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	<p>that she utilized a lipped plate.</p> <p>Observation on 12/27/21 at 11:09 a.m. revealed Staff B assisted the resident to the standing scale and the resident's weight at that time measured 118 pounds.</p> <p>Review of the resident's weight history revealed the following weight measurements:</p> <ul style="list-style-type: none"> a. On 6/29/21 the resident weighed 147.5 pounds. b. On 7/20/21, the resident weighed 146 pounds. c. On 8/17/21, she weighed 143 pounds. d. On 9/28/21, the resident weighed 150 pounds. e. On 10/26/21, she weighed 129.5 pounds. f. On 11/23/21, the resident weighed 129 pounds. g. On 12/17/21 and 12/27/21, the resident's weight measured 118 pounds. <p>The resident had a total weight loss of 29.5 pounds since 6/21.</p> <p>Observation on 12/27/21 at 11:57 a.m. revealed Resident #8 sitting in a wheelchair in the main dining room waiting to eat lunch. The resident had her head down and she appeared to be asleep. At 12:15 p.m. staff served the resident her noon beverages which she picked up and began to drink immediately. Resident #8 drank a cup of coffee with milk and 1/2</p>				
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	<p>glass of water. The resident pushed herself away from the table and did not eat food at the time. The staff failed to redirect the resident back to the table.</p> <p>Observation on 1/4/22 at 12:13 p.m. revealed dietary staff served Resident #8 a carton of skim milk which the resident readily drank.</p> <p>3. According to the MDS assessment dated 10/25/21, Resident #9 had diagnoses which included dementia, stroke, diabetes mellitus and depression. The resident required limited assistance of 1 staff for transfers, walking, dressing, toilet use and personal hygiene. The resident had a BIMS score of 13, indicating intact memory and cognition. The resident utilized a walker to move about the facility. The resident required supervision during meals.</p> <p>The resident's Care Plan, updated on 12/1/21, informed staff the resident had a potential for unintended weight loss related to variable oral intakes and dysphasia. The Care Plan directed staff to supervise the resident during meals, follow safe swallowing techniques, monitor and record meal intakes, offer bed time snack daily, serve supplements as order and to provide her altered diet as prescribed by the physician.</p>			
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	<p>Review of the Meal Consumption report dated 12/17/21 - 1/4/22 revealed the staff failed to document meal consumption for 49 out of 60 meals and during 2 of those meals, the resident consumed less than 25% of her meals.</p> <p>Review of a Quarterly Dietary Note dated 12/1/21 revealed the resident's current weight at 136 pounds, down 3.4% in last 6 months. The resident received a pureed diet, had gastroparesis and her meal observations revealed poor overall dietary intakes. The Dietician noted the resident liked to receive her supplements with meals.</p> <p>Review of the Diet Type Report dated 12/15/21 indicated Resident #9 had a regular, pureed with regular consistency liquid diet. The diet order sheet did not indicate the resident received dietary supplements, with or without her meals.</p> <p>Observation on 12/27/21 at 11:27 a.m. revealed Resident #9 in her bed with night clothes on. Staff A entered the room and stated the resident had not been up yet today. When asked if she had been up this morning, Resident #9 stated no, no one helped her that morning. The resident denied having breakfast that morning when asked.</p>			
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	<p>Review of the resident's weight history revealed the following weight measurements:</p> <ul style="list-style-type: none"> a. On 5/10/21 the resident weighed 140.8 pounds. b. On 6/28/21 the resident weighed 131 pounds c. On 7/29/21 the resident weighed 130 pounds. d. On 8/23/21 she weighed 129 pounds e. On 9/27/21 the resident weighed 127 pounds f. On 10/25/21 the resident weighed 133 pounds g. On 11/16/21 the resident weighed 136 pounds h. On 12/27/21 she weighed 136 pounds. <p>Observation on 12/27/21 at 12:40 p.m. revealed Resident #9 sitting alone in the dining room. The resident consumed a container of vanilla pudding and drank a glass of thickened water independently, but the plate of pureed food in front of the resident was untouched. The dietary staff failed to serve the resident a supplement with this meal.</p> <p>During an interview with Staff G, Food Service Supervisor on 1/4/22 at 1:43 p.m. Staff G stated they do not have a solid method to tell if a resident came to the dining room for a meal. Staff G stated the nursing staff are responsible to fill out the dietary request slips but they are not consistently done. Dietary staff would know at the end of serving a meal, if the dietary slip remained, the resident did not show</p>				
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	<p>up for a meal, but stated again the dietary slips are not consistently completed. The facility had no real way to tell if a resident attended a meal. Staff G stated the nursing department is responsible to complete and document the resident's meal consumption for each meal. They are documented in Point Click Care electronic charting.</p> <p>During an interview with Staff I, Registered Dietician on 1/5/22 at 10:30 a.m. Staff I stated she was aware of the issues regarding Residents #4, #8 and #9 not getting down to breakfast the morning of 12/27/21. Staff I stated she is following all three of the residents for weight loss. Staff I stated the dietary department has system breakdowns and is working with the FSS and other dietary staff to put measures in place to assure the residents get to meals.</p>			
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	FACILITY RESPONSE:				
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