STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 01/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION PARK HEALTH SERVICES	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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	INITIAL COMMENTS Correction Date 1-30-18 The following deficiency was identified during investigation of complaint 71962-C investigated 12/4-12/5/17. Complaint 71962-C was substantiated. (See Code of Federal Regulations (42CFR) Part 483, subpart B-C.)	F 000		
F 325 SS=G	MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE CFR(s): 483.25(g)(1)(3) (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to ensure Resident #5 maintained acceptable parameters of nutritional status and failed to provide the	F 325		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tammy Bushong, LNHA | TITLE: Admin | (X6) DATE: 2/27/18

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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F 325	Continued From page 1 nutritional supplements as recommended to the resident in order to prevent a significant weight loss. The sample consisted of 4 residents and the facility reported a census of 61 residents. Findings include: 1. The physician History & Physical document dated 3/18/17, identified Resident #5 had diagnoses that included bipolar disorder (mental illness), schizoaffective disorder (mental illness), and post-traumatic stress disorder and left hearing loss for Resident #5. The Minimum Data Set (MDS) assessment with a reference date of 9/15/17 indicated the resident had a Brief Interview of Mental Status (BIMS) score of 6. A score of 6 identified the resident with a severe cognitive impairment. The MDS indicated the resident required set-up and supervision for eating and had no significant weight loss of 5% or more in 1 month or 10% for more in 6 months. The Care Plan identified a problem dated 9/12/17 that the resident at risk for weight loss related to the diagnoses of bipolar and schizoaffective disorders and paranoia. The Care Plan approach indicated the resident able to feed herself but may require assistance at times and preferred to eat meals in the Restorative Dining Room. The Care Plan goal plan identified the resident would consume 50-75% for 2 of 3 meals each day and maintain a healthy weight. The form titled Quarterly Nutritional Progress Note, signed by the consulting dietician dated 9/14/17, identified the resident with a significant weight loss of 5.4% in 30 days and 7.9% in 90 days. The note indicated the dietician questioned the accuracy of the admission weight. The	F 325		

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F 325	Continued From page 2 dietician recommended the resident weighed weekly for monitoring purposes. The MDS dated 9/15/17 failed to contain this information. The documentation completed by the consulting dietician dated 10/12/17, indicated the resident refused breakfast and lunch on this day. The dietician recommended the resident receive 60 milliliters (ml) of 2 Cal supplement 3 times daily (TID) due to meal refusal and overall downward weight trend. Documentation completed by the consulting dietician on 11/9/17 documented the resident had a significant weight loss of 5.8% in 30 days and 12.2% in 90 days and 18.8% in 180 days. The note further documented the resident currently being seen by the speech therapist and the resident requires direct feeding assistance most of the time. The dietician recommended increasing the 2 Cal supplement to 60 ml four times a day (QID) and Ensure supplement offered when meals are refused. The ST (speech therapy)-Therapist Progress & Discharge Summary dated 11/29/17 indicated the resident treated by the therapist 11/1-11/29/17 for oral phase dysphagia (difficulty swallowing). The summary documented the resident requires assistance with feeding due to difficulty following commands and noted poor hand-motor coordination with decreased visual and depth perception and the resident would remain seated at the assisted dining table for meals. Continuous observation of the resident in the dining room beginning at 11:40 AM identified the following:	F 325		

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F 325	Continued From page 3 At 11:40 AM-resident seated in wheelchair at table with 2 other residents. At 11:43 AM-dietary aide pours resident beverages into 2-handled cups in front of the resident. At 12:01 PM-resident food served. Staff did not unwrap [open] the resident's silverware or open the package that contained a dinner roll and prepare it for the resident. At 12:10 PM-resident has not initiated feeding self; remained seated in the wheelchair with eyes closed and leaning slightly to the right. Staff A, certified nursing assistant (CNA) sat at the resident's table to visit with another resident. Staff A observed Resident #5 but did not attempt to assist her. At 12:17 PM-Staff A sat on the resident's left side and handed the resident a spoon and then left the table. At 12:23 PM-observer requested Staff A taste the resident mashed potatoes/gravy and ground turkey with 2 separate disposable spoons. When asked if the food items were palatably hot, Staff A replied "not at all". Staff A did not reheat the resident's food or ask the resident about an alternate meal selection. At 12:25 PM-Staff B, CNA, sat down on the resident's left side and offered the resident a bite of mashed potatoes and gravy. Staff B cued the resident to take a bite but the resident refused. At 12:31 PM-Staff B transported the resident out of the dining room. On 12/5/17 at 8:15 AM, Staff C, CNA/restorative aide, was interviewed and stated Resident #5 needs fed by staff as over the last couple of months the resident had a decline and sometimes pockets food in her mouth but often refuses meals and/or assistance.	F 325		

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F 325	Continued From page 4 On 12/5/17 at 9:20 AM, Staff B, CNA, was interviewed and stated the resident needs to be fed by staff. Staff B stated the resident has really declined over the last 2 months. Staff B stated the resident often refuses meals and/or lets food run out the sides of her mouth. Review of the meal consumption record for Resident #5 dated 11/16/17 through breakfast 12/5/17, identified the resident refused 33 of 84 meals served. Review of the Medication Administration Record (MAR) for November and December, 2017 revealed staff only offered a can of Ensure supplement 1 time on 11/16/17 and 2 times on 12/1/17 since order received on 11/16/17. On 1/29/18 at 2:27 PM the resident's physician was interviewed and stated she was aware of the resident's significant weight loss and felt it is unavoidable due to the resident's diagnoses of bipolar and schizoaffective disorders. The physician stated being aware the resident often refused meals and/or eating assistance but would expect staff to attempt to assist the resident with eating and would also expect staff provide the resident assistance with drinking a can of Ensure if refuses meals as ordered.	F 325		

F325

Resident #5 and residents with a physician ordered dietary supplement will have the ordered dietary supplement documented on their medication administration record with the amount or percent consumed noted.

Resident #5 and residents will receive set up assistance at each meal if they are unable to complete this independently and will also receive feeding assistance if they are unable to feed themselves independently.

Resident #5 and current residents with a significant weight loss have this identified on their MDS. Resident #5 MDS has been corrected to accurately reflect her current weight.

Refusals of a physician ordered dietary supplement will be documented on the resident medication administration record as a refusal.

Staff education completed on 12/12/17 at the all staff meeting regarding providing set up assistance to the residents who are unable to complete it independently and providing feeding assistance to the residents who are unable to feed themselves independently.

Staff education completed on 12/12/17 at the all staff meeting regarding documentation of ordered dietary supplements.

Current residents' most recent MDS have been audited for accuracy with weight and identifying any significant weight change. Weight meetings will continue weekly with attendance by the dietician, director of nursing or assistant director of nursing, and MDS/Care plan coordinator. Residents with a significant weight loss will be identified for MDS and Care Plan review.

Residents with ordered dietary supplements will have their medication administration record reviewed twice per week x 4 weeks, then weekly x 4 weeks, then twice per month x 2 months, then monthly x 2 months, then continued periodic reviews by the dietician, director of nursing, assistant director of nursing, or designee. This will be reviewed through the QA process.

Dining room service will be monitored to ensure residents are receiving set up assistance as needed and feeding assistance as needed, twice weekly x 4 weeks, then weekly x 4 weeks, then twice per month x 2 months, then monthly x 2 months by the dietician, director of nursing, administration or designee. The dining service will continue to be monitored by a designated staff member at a minimum of 1 meal per week continuously as a system change. This will be reviewed through the QA process.

An MDS audit for coding of significant weight losses will be completed 1 x per month by the dietician or dietary manager for 3 months. Union Park has instituted an electronic health record. Weights entered for each resident will transfer electronically to the MDS which will eliminate coding errors. This will be monitored through the QA Process.