DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165206	A. BUILDING _____ B. WING _____	12/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE CARE CENTER	600 MORNINGSIDE STREET IDA GROVE, IA 51445

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F 000	INITIAL COMMENTS Correction date 1/11/19 The following deficiencies result from the facility's annual health survey. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy	F 625		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 1-2-2019

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.

POC accepted 1/4/19 VC

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F 625	Continued From page 1 described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility policy review, staff failed to notify a resident or his representative of the bed hold option for one of four residents reviewed for hospitalization (#30). The facility reported a census of 28 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #30 dated 0/23/18, listed diagnoses that included chronic obstructive pulmonary disease with (acute) exacerbation, hypertension, atrial fibrillation, heart failure and acute embolism and thrombosis in the lower extremity. The resident needed the assistance of two staff with bed mobility, transfers, ambulation, dressing, toilet use and personal hygiene. Review of the Nurse's Progress Notes dated 10/22/18 at 1:45 p.m., documented an Advanced Registered Nurse Practitioner gave a phone order to transport Resident #30 to the Emergency Room to be evaluated and treated. Staff documented sending the face sheet, medication sheet, bed hold policy, advance directives and DNR (do not resuscitate) status with the resident's paperwork. The resident's wife was at the bedside and aware of the transfer. Review of the Nurse's Progress Notes dated 10/22/18 at 3:51 p.m. documented the resident as on observation status at the hospital. Documentation of notification of resident or his representative regarding the bed hold policy was	F 625		

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F 625	Continued From page 2 absent from the resident's health record. During an interview on 12/13/18 at 9:10 a.m., the facility's Corporate Nurse confirmed and verified the clinical record lacked documentation of discussion of the bed hold policy at the time of the resident's transfer. Review of a policy from the Admission Agreement packet labeled Bed Hold Policy documented and signed by the resident on 10/8/18 revealed: BEDHOLD-HOSPITAL OR THERAPEUTIC LEAVE If you are hospitalized or on an arranged leave of absence and wish to reserve a place of Facility, we will hold your place at the applicable Daily Rate for bedhold days determined by state law for so long as payment for such services is received or as otherwise set forth in Facility bedhold policy. Please arrange this with your designated social worker. Bedhold payments are non-refundable. Facilities bedhold policy is included in the Notices provided to you concurrently with this Agreements and is also available upon request.	F 625		
F 644 SS=B	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the	F 644		

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F 644	Continued From page 3 PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to repeat a Level 1 Preadmission Screening and Resident Review (PASRR) when a resident entered the facility with a diagnosed mental disorder not documented on a previous Level 1 PASRR and a new mental disorder diagnosis had been given after admission to the facility for one of two residents reviewed for PASRR requirements (Resident #13). The facility reported a census of 28 residents. Findings include: According to an Admission Record form, staff documented Resident #13's admission to the facility as 3/22/17. A Diagnosis Report form dated 12/11/18 documented the following diagnosis and associated dates of the diagnosis: 3/22/17 - anxiety disorder 4/10/17 - delusional disorder An Inter-facility Transfers to Nursing Facility Admission Orders form dated 3/22/17 recorded Resident #13's medications included the following psychotropic medications (mind altering	F 644		

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F 644	Continued From page 4 medications): lorazepam (anti-anxiety), olanzapine (antipsychotic), risperidone (antipsychotic) and Zoloft (antidepressant). According to the Order Summary Report form dated 11/281/8, Resident #13 continued to receive lorazepam and risperidone. A Notice of Negative Level 1 Outcome form, with a mailing date of 3/21/18, documented a Level 1 PASRR. The form included guidance that no further Level 1 screening would be needed unless in the case of a known or suspected major mental illness. The same PASRR form documented Resident #13 had been assessed without a mental disorder (such as anxiety disorder) even though the resident had been admitted to the facility on 3/22/17 with a diagnosis of anxiety disorder. The resident received the diagnosis of delusional disorder on 4/10/17 and the facility failed to re-submit a Level 1 PASRR for review to the contracted screening agency. During interview on 12/12/18 at 8:05 A.M., the Director of Nursing (DON) stated the resident's Level 1 PASRR had more than likely been completed prior her admission to the facility. The DON stated she did not work at the facility in 2017 and did not know why the Level 1 was not re-submitted after the resident was diagnosed with a delusional disorder.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning	F 655		

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F 655	Continued From page 5 §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.	F 655		

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F 655	Continued From page 6 (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide a written summary of the baseline care plan to the resident and his/her representative for three of 12 current residents reviewed (Residents #3, #6, and #30). The facility reported a census of 28 residents. Findings include: 1. According to the admission Minimum Data Set (MDS) assessment dated 6/11/18, Resident #3's diagnoses included cancer and dementia. The resident's clinical record contained a care plan initiated on 6/6/18. However, it lacked documentation of providing the resident or his representative a written summary of the baseline care plan. During an interview on 12/12/18 at 7:20 a.m. the Director of Nursing (DON) stated they had nothing to show they provided a written summary of the baseline care plan. 2. According to the admission MDS assessment dated 1/25/18, Resident #6's diagnoses included diabetes and a hip fracture. A Care Plan showed the facility completed a baseline care plan on 1/19/18. Review of the clinical record lacked documentation of providing the resident or her representative a written summary of the baseline care plan. During an interview on 12/12/18 at 7 a.m. the	F 655		

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F 655	Continued From page 7 DON stated they did not have documentation they provided a written summary of the baseline care plan to the resident or her representative. 3. Review of the 72 hour Transitional Care Meeting and Discharge Plan with an Initial Admission Date of 10/8/18, for Resident #30, documented that neither he nor his representative were involved in the care plan meeting. Review of resident's documentation showed no review of initial care plan with resident or resident representative. In an interview on 12/13/18 at 8:50 a.m., the facility Social Service Director verified the lack of documentation to show initial care plan review with either the resident or his representative(s).	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		

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F 656	Continued From page 8 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop the comprehensive care plan that addressed psychotropic medications and weight loss for one of 12 current residents reviewed (Resident #6). The facility reported a census of 28 residents. Findings include: 1. A Care Area Assessment (CAA) for Resident #6 dated 6/29/18 documented psychotropic medications would be addressed in her care plan because of the risk for complications related to long term medication use. Care planning would	F 656		

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F 656	Continued From page 9	F 656		

address this concern to avoid complications with interventions to promote optimal drug dosing.

According to the Minimum Data Set (MDS) assessment dated 9/29/18, Resident #6 scored 7 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The assessment documented she received antipsychotic and anti depressant medications.

The Electronic Medication Administration Record (EMAR) for December 2018 recorded Resident # 6 received the psychotropic medications Sertraline (antidepressant), Trazadone (antidepressant), and Risperdone (antipsychotic).

The current Care Plan initiated on 5/8/18 identified Resident #6 as cognitively impaired. The interventions instructed to give her medications as ordered, she preferred crushable meds crushed and given in applesauce.

The care plan revised 6/25/18 identified Resident #6 had a history of depression and recently made statements that she wanted to kill herself. She was also observed with a gait belt around her neck. The interventions included to give medications as ordered. The care plan also identified a focus of taking medications at home or at the hospital. Interventions directed to keep her informed of current medications and treatments, she preferred crushable meds crushed and given in applesauce and would receive medications and treatments as ordered. Her current medication orders and treatments can be found on the physician order page in the chart and current medications and treatments are listed on the EMAR. Spoon the medications to the resident and tell her when staff were going to

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F 656	Continued From page 10 give them. The care plan lacked identification of the use of the psychotropic medications or interventions to promote optimal drug dosing as documented in the 6/29/18 CAA. During an interview on 12/12/18 at 2:01 p.m. the Nurse Consultant verified the psychotropic medications were not addressed on the resident's care plan. 2. The MDS assessment dated 9/29/18 documented Resident #6 required limited assistance with eating and had diagnoses that included diabetes and Alzheimer's disease. The Care Plan revised 4/15/18 identified Resident #6 would consume foods in the dining room. The interventions included she would consume foods in the dining room where staff supervised her and could have a room tray as needed with staff supervision. The staff should weigh her per facility policy and report significant changes to the dietary department, family, nursing staff and her physician, and staff would give her diet as ordered and record the foods consumed daily, and monitor for changes in normal intakes. A Nutrition Assessment by the Consultant Dietitian dated 10/4/18 documented the resident's weight at 113 pounds which showed a significant weight loss from 1, 3 and 6 months. Resident #6 remained on a regular diet with regular liquids and had no chewing or swallowing difficulties on her current diet. Meal intakes remained per the resident's usual, averaging 27 - 50% with 163 cc (cubic centimeters) per meal fluid intake. Her	F 656		

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weight had been relatively stable since mid July with the exception of one weight in September of 119#. Resident #6 started on 120 cc Boost Breeze back in July due to the weight loss history and her weight stabilized. The assessment documented no new nutritional concerns noted and no new recommendations. The dietitian expected Resident #6 to be able to maintain her weight with continued usual meal acceptance and continued acceptance of her nutritional supplement. She planned to continue with current plan of care and follow up as necessary/requested.

A Weight Change Note dated 11/29/18 documented the resident triggered for a significant weight loss of 13 pounds (10.5%) from 6/4/18 weight of 124 pounds. Weight recently went down 5 pounds in the past two weeks; request re-weigh to ensure accuracy. Her weight since mid July has ranged from 111 - 119 pounds with fluctuations over that time frame. Her meal intakes this past week averaged 26 - 50% per her usual. The resident occasionally took a PM or HS snack. She is provided with 120 cc Boost Breeze 3 times a day (TID) due to previous weight loss and it is documented as accepted 100%. Resident #6 had dementia and would act out at times. The Dietician would monitor for her re-weigh and continue with current plan of care.

A Nutrition Update dated 12/6/18 documented Resident #6 with decreased meal acceptance, down this past week, averaging 17 - 38% overall. She continued to receive 120 cc Boost Breeze TID to help with weight maintenance. Staff obtained no new weight from the previous weight on 11/21/18 of 111 pounds which was down significantly. The Dietitian suggested offer of a

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F 656	Continued From page 12 magic cup or ice cream at the end of meals to boost her calorie offering and obtain a new weight as able. The care plan did not identify the resident had a significant weight loss or interventions to prevent further weight loss. The facility's Weight Policy revised 3/16 documented that care planning for weight loss or impaired nutrition would be a multidisciplinary effort. Individual care plans should address to the extent possible the identified cause of weight loss, goals and benchmarks for improvement and time frames and parameters for monitoring and reassessment.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		

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F 657	Continued From page 13 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to document the resident and/or family members attendance at care planning meetings and failed to always document care plan conferences held for five of 12 current residents reviewed (Residents #3, #5, #6, #13 and #22). The facility reported a census of 28 residents. Findings included: 1. Review of Resident #3's Minimum Data Set (MDS) tracking form revealed facility staff completed annual or quarterly MDS assessments on 6/11/18, 9/11/18 ad 12/12/18. Review of Multidisciplinary Care Conference (care plan conference) Summary forms revealed care conferences were held only on 9/24/18. The care conference form lacked documentation the resident or the resident's representative attended the meeting. 2. Review of Resident #5's MDS tracking form revealed facility staff completed annual or quarterly MDS assessments on 12/7/17, 4/11/18, 7/12/18 and 9/16/18, Review of care plan conference forms revealed	F 657		

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F 657	Continued From page 14 care conferences held only on 7/30/18 and questionably following the 9/16/18 MDS assessment as the care conference form lacked a meeting date. The care conference held 7/30/18 revealed resident representatives attended the meeting. 3. Review of Resident #6's MDS tracking form revealed facility staff completed annual, significant change or quarterly MDS assessments on 1/25/18, 4/27/18, 6/29/18 and 9/29/18. Review of care plan conference forms revealed care conferences only held on 5/14/18 and possibly on following the MDS assessment completed 9/29/18, as the care plan conference form lacked a meeting date. The care conference forms lacked documentation the resident or the resident's representative attended the meeting. 4. Review of Resident #13's MDS tracking form revealed facility staff completed annual, significant change or quarterly MDS assessments on 11/15/17, 1/10/18, 3/7/18, 6/7/18, 7/25/18 and 10/25/18. Review of care plan conference forms revealed care conferences questionably held following the 11/15/17 MDS assessment as the care plan conference form lacked a meeting date. Staff documented care plan meetings were held following all other MDS assessments documented above, with the exception of the 7/25/18 MDS assessment. The care conference forms lacked documentation the resident or the resident's representative attended any of the meetings, with the exception of a meeting held 12/10/10.	F 657		

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F 657	Continued From page 15 5. Review of Resident #22's MDS tracking form revealed facility staff completed annual or quarterly MDS assessments on 11/15/17, 2/15/18, 5/18/18, 8/18/18 and 11/14/18. Review of care plan conference summary forms revealed care conferences held on 11/16/17, questionably following the 2/15/18 MDS assessment as the care plan conference form lacked a meeting date and 12/3/18. Further review of the care plan conference forms lacked documentation the resident or a representative attended the meeting. During interview on 12/12/18 at 9:15 A.M., the facility Social Worker (SW) confirmed the facility had not always documented residents or representatives who attended the care plan conferences. On 12/13/18 at 8:55 A.M., the SW stated she had no explanation for not always having documentation in regards to care planning meetings held. The facility's Care Planning policy, with a revision date of 11/2017, documented the following procedure: Resident care conferences are held within the first 21 days of admission and at least quarterly thereafter. Residents and resident representatives will be invited to the care conference. This will be documented in a care plan progress note. The care conference is intended to be an interactive meeting with the resident, resident representative(s) and interdisciplinary team (facility staff) to review the care plan, clarify service and contact information and to provide a forum for the resident and/or resident representative(s) to relate satisfaction or dissatisfaction with care.	F 657		

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F 688	Continued From page 16	F 688		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to assure residents received range of motion (ROM) restorative programs as planned for two of two residents reviewed (Residents #6 and #23). The facility reported a census of 28 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 9/29/18, Resident #6 scored 7 on the Brief Interview for Mental Status (BIMS) test indicating severe cognitive impairment. The resident's diagnoses included diabetes and Alzheimer's disease. The assessment documented she required the assistance of two	F 688		

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F 688	Continued From page 17 staff with bed mobility, transfers, walking, dressing, toilet use and personal hygiene. The MDS also documented she had no ROM limitations. The resident's Care Plan dated 10/15/18 identified she had a functional maintenance program, with a goal to maintain her current level of mobility and not develop contractures or ROM limitations. One intervention instructed to encourage the resident to participate in her exercise program. The task for nursing rehab directed provision of active ROM upper extremity exercises each exercise 10 times and to complete the program three times a week. The task documented the resident completed the exercises only five times in the previous 30 days. During an interview on 12/12/18 at 11:10 a.m. the Director of Nursing (DON) stated she found no additional documentation regarding the completion of the resident's restorative program. 2. According to the MDS assessment dated 11/14/18, Resident #23 scored 14 on the BIMS test indicating no cognitive or memory impairment. The resident had functional limitation in his ROM of the upper and lower extremities on both sides. The current Care Plan revised on 8/10/16 identified Resident #23 may need assistance with some or all of his ADL (activities of daily living) skills and toileting due to a history of a ruptured brain aneurysm. The resident had a goal to remain at his current ROM level. The interventions included to encourage Resident #23	F 688		

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F 688	Continued From page 18 to participate in his restorative program, initiated on 4/10/18. A Physical Therapy Discharge Summary dated 11/3/18 documented a goal for Resident #23 to tolerate and participate in an appropriate Restorative Care Program (RCP) with the assistance of trained caregivers 3-5 times a week in order to further and maintain strength, ROM and balance to facilitate his best ability to function was met on 11/23/18 and an updated RCP established. The task for Lower extremity ROM, sit to stand transfer, and standing balance, documented the resident completed it once since 11/23/18. On 12/12/18 at 11:10 AM the DON stated Resident #23 had a re-evaluation for a restorative program in November. She thought the program is done more than documented, but they are not taking credit for it. The could not provide any additional documentation of completing the resident's restorative program.	F 688		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(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- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte	F 692		

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F 692	Continued From page 19 balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(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 clinical record review, observation, staff interview and facility policy review, the facility failed to implement nutritional recommendations for two of two residents reviewed with weight loss (Residents #6 and #13). The facility reported a census of 28 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 9/29/18, Resident #6 scored 7 on the Brief Interview for Mental Status (BIMS) test indicating severe cognitive and memory impairment. The resident required limited assistance with eating. Her diagnoses included diabetes and Alzheimer's disease. The MDS indicated the resident weighed 113 pounds and had no weight loss in the past month or past 6 months. The Care Plan revised 4/15/18 identified Resident #6 would consume her foods in the dining room. The interventions included: a. Resident #6 would consume foods in the dining room where staff supervised her and she could have a room tray as needed with staff supervision.	F 692		

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F 692	Continued From page 20 b. Staff to weigh her per facility policy and report significant changes to dietary staff, family, nursing and her physician, c. Staff would provide her diet as ordered and record the foods and foods consumed daily, and monitor for changes in normal intakes. A Nutrition Assessment by the Consultant Dietitian dated 10/4/18 documented the resident's weight at 113 pounds which showed a significant weight loss from 1, 3 and 6 months. Resident #6 remained on a regular diet with regular liquids and had no chewing or swallowing difficulties on her current diet. Meal intakes remained per the resident's usual, averaging 27 - 50% with 163 cc (cubic centimeters) per meal fluid intake. Her weight had been relatively stable since mid July with the exception of one weight in September of 119#. Resident #6 started on 120 cc Boost Breeze back in July due to the weight loss history and her weight stabilized. The assessment documented no new nutritional concerns noted and no new recommendations. The dietitian expected Resident #6 to be able to maintain her weight with continued usual meal acceptance and continued acceptance of her nutritional supplement. She planned to continue with current plan of care and follow up as necessary/requested. A Weight Change Note dated 11/29/18 documented the resident triggered for a significant weight loss of 13 pounds (10.5%) from 6/4/18 weight of 124 pounds. Weight recently went down 5 pounds in the past two weeks; request re-weigh to ensure accuracy. Her weight since mid July has ranged from 111 - 119 pounds with fluctuations over that time frame. Her meal intakes this past week averaged 26 - 50% per her	F 692		

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F 692	Continued From page 21	F 692		

usual. The resident occasionally took a PM or HS snack. She is provided with 120 cc Boost Breeze 3 times a day (TID) due to previous weight loss and it is documented as accepted 100%. Resident #6 had dementia and would act out at times. The Dietician would monitor for her re-weigh and continue with current plan of care.

A Nutrition Update dated 12/6/18 documented Resident #6 with decreased meal acceptance, down this past week, averaging 17 - 38% overall. She continued to receive 120 cc Boost Breeze TID to help with weight maintenance. Staff obtained no new weight from the previous weight on 11/21/18 of 111 pounds which was down significantly. The Dietitian suggested offer of a magic cup (a supplement) or ice cream at the end of meals to boost her calorie offering and obtain a new weight as able.

Facility staff documented the task of receiving supplement with meals as not applicable from 12/6 to 12/11/18.

The clinical record lacked any additional weights of the resident since 11/21/18.

During an observation on 12/11/18 at 8:31 a.m. Resident #6 sat at the dining room table A Certified Nursing Assistant (CNA) asked the resident if she was finished and she said yes, and removed the resident from the table. The resident did not receive ice cream or magic cup.

During an observation on 12/12/18 at 8:10 a.m. the resident received breakfast which included a waffle, bacon, and ice cream. Staff cut up the waffle. The resident fed herself several bites of the waffle and the bacon then picked up the ice

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cream cup and attempted to drink then sat it back down. Staff did not intervene. While not eating, staff at the table assisting another resident asked if Resident #6 was done, then asked another staff member to get her a washcloth. The resident then took another bite of food. Staff brought medication for the resident and after that, she stated she felt full. The staff member who gave her the medication told her she had ice cream and the resident said no.

During an interview on 12/12/18 at 7:16 a.m. the Director of Nursing (DON) checked and stated the resident was scheduled to have a weight taken 12/19/18, but they could weigh her today.

The Weights and Vitals summary showed the resident weighed 106 pounds on 12/12/8 at 10:04 a.m., an additional 5 pound weight loss or a 14.5% loss from 6/4/18.

During an interview on 12/12/18 at 11:05 a.m. Staff B Cook stated they counted ice cream as a liquid. She said there would be no way to know if the resident ate the ice cream in their documentation. She said she did not consider the ice cream a supplement and the resident did not eat any today.

During an interview on 12/12/18 at 11:10 a.m. the DON stated she did not know why they had not re-weighed the resident since 11/21/18. She said staff may need some re-education on providing encouragement to the resident with her meals.

During an interview on 12/12/18 at 11:15 a.m. the Dietary Supervisor stated they should be documenting the ice cream as a supplement to the resident's diet and documenting how much

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F 692	Continued From page 23 she consumed. She said they had weekly meetings with the dietician and a nurse. She did not know why the resident did not get re-weighed as the Dietician requested. During an interview on 12/12/18 at 11:39 a.m. the Dietician stated she thought they would reweigh the resident and thought staff weighed residents every two weeks. She said she didn't think they documented the ice cream or magic cup at meals; she relied on the staff telling her if the resident took it or not. She thought it would be great if they did document it. She said the resident should receive the ice cream or magic cup at the end of each meal. The facility Weight Policy revised March 2016 documented the multidisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for our residents. The procedure included the nursing staff would measure the resident's weights on admission and per registered dietician recommendation thereafter but at least monthly. Any weight discrepancy would be reviewed by the nurse/nurse manager to determine if a re-weight was needed. The Dietician would review the unit weight record and follow individual trends over time. Negative trends would be evaluated by the treatment team whether the criteria for significant weight change had been met. The threshold for significant unplanned and undesired weight loss would be based on the following criteria: 1 month 5% loss significant; greater than 5% severe, 3 months 7.5% significant; greater than 7.5% severe, 6 months 10% weight loss significant, greater than 10% severe. Care Planning for weight loss or impaired nutrition would be a multidisciplinary effort. Individual care plans	F 692		

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F 692	Continued From page 24 should address to the extent possible the identified cause of weight loss, goals and benchmarks for improvement, and time frames and parameters for monitoring and reassessment. 2. According to an Order Summary Report form dated November 28, 2018, Resident #13's diagnoses included dementia, delusional disorder and abnormal weight loss. The MDS assessment of 10/25/18 identified a BIMS score of 0, indicative of severely impaired cognition. The MDS revealed the resident depended on staff on order to eat. According to a Progress Note dated 2/23/18, revealed the resident admitted to Hospice Services 2/23/18 due to late stage dementia and a post polio diagnosis. A Physician Order Form dated 7/13/18 recorded the resident had been discharged from Hospice Services. According to a Physician's Orders Initial Plan Of Care dated 11/28/18, the resident required re-admission to Hospice services due to dysphasia (difficulty swallowing) and end stage periventricular leukomalacia (brain damage that involves white matter of the brain). The same order sheet included a diet order for pureed food with pudding thickened liquids. According to a Weights and Vitals Summary form dated 12/12/18, staff documented the following weights for Resident #13: 8/28/18 - 91 pounds (lb) 9/13/18- 90 lbs	F 692		

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F 692	Continued From page 25 9/25/18 - 90 lbs 10/9/18 - 94.2 lbs 10/23/18- 92 lbs 11/6/18 - 90 lbs 11/20/18- 85 lbs 11/28/18- 91 lbs 12/4/18 - 88 lbs Review of RD (Registered Dietitian) Nutritional Assessment Updated forms included the following: a. Effective date 10/30/18 - Quarterly Nutrition Assessment- Resident #13 remained on a pureed diet. Her meal intakes remained good with resident accepting 76- 100 % of most meals fed to her. Resident #13 is offered magic cup at meals to aid in weight maintenance. b. Effective date 12/6/18 - Resident #13 recently returned from the hospital due to hypernatremia (high blood sodium levels), pneumonitis and chronic kidney disease. The resident is now on Hospice cares. During hospitalization, the resident had difficulty with swallowing and tolerated her diet fairly well with intakes averaging 60 -84% at meals. Her current weight of 88 pounds is down 3 pounds from the re-admission weight and trending down. The resident had the risk for continued nutritional declines. A Care Plan with a print date of 12/11/18 included a focus area (with a date initiated date of 4/3/17 and revision date of 12/10/18) that Resident #13 had a terminal diagnosis of dysphasia and significant weight changes would not be unexplained or unexpected due to the need for Hospice care. The care plan lacked any direction for the provision of magic cup supplement.	F 692		

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F 692	Continued From page 26 Observation on 12/10/18 at 12:30 P.M. revealed Resident #13 sat at a dining room table in a wheelchair (w/c) being fed by staff. The resident took bites when offered. According to an amount eaten form, the resident ate 50-75 % at the noon meal. The observation revealed no magic cup offered at the same noon meal. Observation on 12/11/18 at 8:38 A.M., revealed Resident #13 in a dining room, being fed by Staff A, Certified Nurse Aid (CNA) no offer of a magic cup supplement. According to an amount eaten form, the resident ate 76 - 100% at the breakfast meal. During interview on 12/11/18 at 8:39 A.M., Staff B, confirmed Resident #13 did not receive magic cup regularly and only received magic cup when ice cream had been on the menu. During a phone interview on 12/11/18 at 9:36 A.M., the facility Dietitian confirmed she expected staff to offer magic cups to residents per her recommendations. She stated she communicates her recommendations to the facility by giving the facility Dietary Supervisor a copy of her notes and/or assessments. She stated, more than likely, Resident #13 would consume the magic cups if offered. Observation on 12/11/18 at 12:30 P.M., revealed the resident being fed by staff in a dining room and received no Magic Cup with her meal. Observation on 12/11/18 at 12:45 P.M. revealed the resident remained at the same dining room table and no Magic Cup offered. According to an amount eaten form, the resident ate 50 -75% of	F 692		

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	165206	A. BUILDING _____ B. WING _____	12/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE CARE CENTER	600 MORNINGSIDE STREET IDA GROVE, IA 51445

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F 692	Continued From page 27 the noon meal. During interview on 12/12/18 7:12 A.M., the Director of Nursing (DON) stated there had been no recommendation from the Dietitian for Resident #13 to have a Magic Cup with meals. The DON confirmed not being aware of the Dietitians note 10/2018 in regards to a Magic Cup with meals. During interview on 12/12/18 at 7:15 A.M., the DON identified Dietary staff as being responsible for the administration of and to monitor those residents who are to receive a Magic Cup. During interview on 12/12/18 at 8:07 A.M., the Dietary Supervisor stated the facility had regular weight meetings with herself, the DON, Dietitian and various staff members. She stated she recalled the discussion in regards to Resident #13's Magic Cup on or about 10/2018. She stated it had not been her responsibility to get physician's orders for dietary supplements and she had just been made aware yesterday that Magic Cup had not required a physician's order. The Dietary Supervisor confirmed Resident #13 had not regularly received a Magic Cup with her meals, but only when ice cream had been on the menu.	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		

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F 758	Continued From page 28 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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F 758	Continued From page 29 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility failed to assure a gradual dosage reduction attempted for one of 16 total residents reviewed (Resident #27). The facility reported a census of 28 residents. Findings included: 1. The Minimum Data Set (MDS) assessment dated 12/02/18 documented Resident #27 had diagnoses that included diabetes mellitus, cerebrovascular accident, Non-Alzheimer's dementia, depression and psychotic disorder. The Brief Interview for Mental Status test documented a score of 5 which indicated severely impaired memory and cognition. The assessment documented the resident with no mood symptoms, such as feeling down, little interest or pleasure in doing things or thoughts he would be better off dead. The MDS also documented the resident received a daily antidepressant during the assessment period. The Order Summary Report signed and dated by the physician on 12/7/18 documented an order to give Mirtazapine (Remeron, an antidepressant) 7.5 milligrams (mg) by mouth one time a day for depression with a start date of 6/1/17. A Consultation Report dated 2/12/18 documented, Resident #27 has been receiving Haldol 2 mg twice daily for delusional disorder and Remeron 7.5 mg every hour of sleep for depression. Please review above for any possible gradual dose reductions while monitoring for	F 758		

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F 758	Continued From page 30 re-emergence of target and/or withdrawal symptoms. The physician responded to decrease the Haldol to 1 mg by mouth twice a day. A fax cover sheet dated 3/5/18 to the physician informed the resident's family as not in agreement with the decrease in Haldol to 1 mg from 2 mg as the resident then begins to see their dead brother and gets mean, isolates himself and argues with himself. The fax requested reconsideration as the resident also carries on full conversations with people who are not present. The doctor responded to resume the previous Haldol dose at 2 mg twice daily and to notify the pharmacy consultant. Interview on 12/12/18 at 1:00 p.m., the Director of Nursing and Corporate Nurse confirmed and verified the clinical record lacked any documentation his Remeron had been attempted for a gradual dose reduction since admission in May of 2017.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		

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F 812	Continued From page 31 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and staff interview, the facility failed to maintain cleanliness in the kitchen to assure sanitary conditions. The facility reported a census of 28 residents. Findings included: 1. Observation during the initial tour of the facility kitchen on 12/10 /18 at 9:00 A.M., revealed the following concerns: a. Two rectangular air ventilation devices near the entrance door contained an excess gray material that resembled dust. b. Six of seven circular ceiling air vents and a ceiling smoke detector had an excess amount of a gray material that resembled dust on the vents and smoke detector. The circular air vents were located over a steam table in the kitchen and over clean dishes that exited a dishwasher. c. A pot rack over a cook's preparation table contained an excess gray material that resembled dust on the pot rack itself. During interview on 12/10/18 at 12:35 P.M., the facility Maintenance Supervisor (MS) reported the large rectangular vents drew out air and the circular vents blew either cool or warm air in. He reported he cleaned all of the vents twice a month, but lacked documentation of the same.	F 812		

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F 812	Continued From page 32 During interview on 12/10/18 at 1:49 P.M., the Dietary Supervisor (DS) stated dietary staff remind the MS every week to clean the air filters in the kitchen and mark it off the cleaning schedule as done. The DS clarified that even though that task had been marked off, it hadn't meant the filters had been cleaned, but only that the dietary staff reminded the MS to clean the filters. The DS confirmed the vents and filters looked dusty and dirty and probably needed to be cleaned. 2. Ongoing observation of the facility kitchen on 12/11/18 at 11:45 A.M. revealed the following concerns: a. A metal stock pot hung on a pot rack over a cook's preparation table. The inside of the pot revealed a dried residue, gray and tan in color, adhered to the inside perimeter of the pot. The stock pot hung on the pot rack with several other clean pots and pans. b. A window over a countertop on the east wall showed marred and gouged wood in the frame of the window and could not be easily sanitized. c. A window on a south wall had a piece of the window frame missing, exposed bare wood and could not be easily sanitized. During interview on 12/11/18 at 12:55 P.M., the DS looked inside the stock pot and confirmed the pot as dirty. The DS wiped some of the residue off of the inside of the pot with her hand . During interview on 12/11/18 at 12:50 P.M. Staff B, Cook, stated the stock pot had sometimes been used for soup or to boil potatoes. A facility Environment policy dated May 2014 instructed the following:	F 812		

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F 812	Continued From page 33 The Food Service Director (Dietary Supervisor) will insure that the physical plant is maintained in a clean and sanitary manner. The Food Service Director will insure that all employees are knowledgeable in the proper procedures for cleaning all food services equipment and surfaces.	F 812		

Plan of Correction for Morningside Care Center 2018

F625 Notice of Bed Hold Policy Before/Upon Transfer

Immediate corrective action:

R30 did not returned to the facility following hospitalization.

Action as it applies to others:

All resident who leave the facility on a therapeutic visit or hospitalization have the potential to be affected.

The Bed Hold Policy remains the same.

Education was provided to staff to provide paperwork to the resident/representative regarding the Bed Hold Policy upon transfer.

Date of completion: 1/11/19

Recurrence will be prevented by:

The medical record will be audited weekly for ensure proper bed hold paperwork was provided to the resident/representative randomly x 30 days and brought to QAPI committee for review and recommendation.

The correction will be monitored by:

Administrator/Designee

F644 Coordination of PASARR and Assessments

Immediate corrective action:

Res #13 information was submitted to ASCEND to ensure a new PASRR was needed or updated.

Action as it applies to others:

All residents with a new diagnosis or mental disorder, intellectual disability, a related condition for a Level II, upon a significant change in status assessment, or come from the community/hospital without the proper diagnosis noted on the Level I have the potential to be affected.

Education was provided to Social Services/MDS Coordinator/DON on the PASRR process.

Date of completion: 1/11/19

Recurrence will be prevented by:

Residents who have a new mental health diagnosis or admit to the facility will be randomly audited weekly for x30 days and brought to QAPI committee for review and recommendation.

The correction will be monitored by:

DON/Designee

F655 Baseline Care Plan

Immediate corrective action:

R3, R6, and their representatives have received a copy of their baseline care plans as well as their current care plans.

R30 did not return to the facility.

Action as it applies to others:

All residents who admit to the facility have the potential to be affected.

MDS Coordinator/Social Services were educated regarding baseline care plans.

Date of completion: 1/11/19

Recurrence will be prevented by:

Weekly audits of residents who require a baseline care plans will be completed randomly x 30 days and brought to QAPI committee for review and recommendation.

The correction will be monitored by:

DON/Designee

F656 Develop/Implement Comprehensive Care Plans

Immediate corrective action:

R6 care plan was updated to reflect psychotropic medications and weight loss.

Action as it applies to others:

All residents have the potential to be affected.

Education was provided to the MDS Coordinator and the IDT on updating care plans.

Date of completion: 1/11/19

Recurrence will be prevented by:

Care plans will be audited randomly weekly x 30 days to ensure they are up to date. The results of these audits will be brought to QAPI Committee for review and recommendation.

The correction will be monitored by:

DON/Designee

F657 Care Plan Timing and Revision

Immediate corrective action:

R3, R5, R6, R13, and R22 and their representatives have had a care conference and is documented in the medical record.

Action as it applies to others:

All residents have the potential to be affected.

Education was provided to the MDS Coordinator and the IDT on documenting when care conferences are held and attendance.

Date of completion: 1/11/19

Recurrence will be prevented by:

Residents who have a care conference that week will be randomly audited weekly x 30 days and brought to QAPI Committee for review and recommendation.

The correction will be monitored by:

DON/Designee

F688 Increase/Prevent Decrease in ROM/Mobility

Immediate corrective action:

R6 and R23 have current ROM programs and are being documented on.

Action as it applies to others:

All residents who have a ROM program have the potential to be affected.

Education was provided to staff on where to document ROM when completed.

Date of completion: 1/11/19

Recurrence will be prevented by:

Residents who have a ROM program will be randomly audited weekly x 30 days and brought to QAPI Committee for review and recommendation.

The correction will be monitored by:

DON/Designee

F692 Nutrition/Hydration Status Maintenance

Immediate corrective action:

R6 and R13 receive their nutritional supplements per recommendations and their care plans are up to date.

Action as it applies to others:

All residents with nutritional recommendation have the potential to be affected.

The facility has hired a new RD and will discuss all nutritional recommendations and weights or needing to re-weigh a resident during their visit.

Nutritional recommendations will be documented on by nursing staff.

Education was provided to the staff on proper documentation of nutritional supplements and assisting residents when needed or allowed by resident.

Date of completion: 12/27/18

Recurrence will be prevented by:

Residents who receive nutritional supplements will be audited weekly x 30 days and brought to QAPI Committee for review and recommendation.

The correction will be monitored by:

DON/Designee

F758 Free of Unnecessary Psychotropic Meds/PRN Use

Immediate corrective action:

R27 medications have been reviewed by the physician and a GDR has been requested. _____

Action as it applies to others:

All residents who receive psychotropic medications have the potential to be affected.

Education was provided to the MDS Coordinator and the IDT on requesting GDRs when necessary.

Date of completion: 1/11/19

Recurrence will be prevented by:

Residents who take a psychotropic medication will be randomly audited weekly x 30 days and brought to QAPI Committee for review and recommendation.

The correction will be monitored by:

DON/Designee

F812 Food Procurement, Store/Prepare/Serve-Sanitary

Immediate corrective action:

The air ventilation devices, ceiling air vents, ceiling smoke detectors, the pot rack, and the metal stock pot, have been cleaned.

The windows have been repaired.

Action as it applies to others:

The items listed have been added to the cleaning list and Maintenance will be documenting when they are cleaned.

Education was provided to the Dietary and Maintenance staff on cleaning of these items.

Date of completion: 1/11/19

Recurrence will be prevented by:

Kitchen sanitation will be audited weekly x 30 days and brought to QAPI Committee for review and recommendation.

The correction will be monitored by:

Administrator/Designee