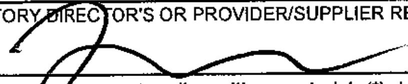
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165017	A. BUILDING ______ B. WING ______	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY CEDAR RAPIDS	1940 FIRST AVENUE NE CEDAR RAPIDS, IA 52402

(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: 1/31/25 The following deficiencies relate to the facility's annual Recertification Survey completed 1/12/25 to 1/15/25 and investigation of Complaint #125717-C. Complaint #125717-C was Not Substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE: Administrator (X6) DATE: 1/31/25

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 578	Continued From page 1 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on Iowa Physician Orders for Scope of Treatment (IPOST) form review, Electronic medical record review, and staff interview the facility failed to ensure consistent documentation of code status for 1 of 24 resident reviewed for advanced directives (Resident #64). The facility reported a census of 77 residents. Findings include: The Minimum Data Set (MDS) assessment dated 11/19/24 revealed Resident #64 medical diagnoses included Heart disease, anemia, acquired absence of parts of digestive tract, and discitis referring to inflammation of the spinal column. The Brief Interview for Mental Status (BIMS) exam scored 15 out of 15 which indicated intact cognition. The electronic medical record, profile sheet for Resident #64 directed, Do not resuscitate, DNR.	F 578		

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F 578	Continued From page 2 The Care Plan revealed a focus initiated 8/14/24 for Resident #64 advance directive status and included intervention, documented, the electronic medical record, chart to identify code status, DNR. An IPOST form signed by Resident #64 on 9/19/24 was located at the nurse's station in the code status binder for staff access in the event of an emergency, directed Cardiopulmonary Resuscitation (CPR). The form was signed by the provider on 10/10/24. During an interview on 01/13/25 at 2:05 PM the Director of Nurses (DON) relayed the nursing staff can go to the electronic medical record to access resident code status or can view the code status from the IPOST document in the code status book. The DON relayed the code status would be the same in either location. The DON acknowledged the electronic medical record and IPOST did not match for Resident #64 and a correction was needed immediately to ensure resident wishes were followed in the event of a cardiac arrest. The DON reported there is not a policy to direct the advance directive process. The staff would follow the standard procedure if a resident requested DNR, the physician order is signed or the IPOST form is used.	F 578		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for	F 640		

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F 640	Continued From page 3 each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must	F 640		

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F 640	Continued From page 4 transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review the facility failed to submit a discharge Minimum Data Set (MDS) within the required time frame for 1 of 3 residents reviewed for MDS (Resident #53). The facility reported a census of 77 residents. Findings include: The MDS for Resident #53 dated 8/27/24 documented a planned discharge from the facility, return not anticipated. Staff B, MDS Coordinator, signed the completed document on 9/4/24. The MDS was not marked as submitted. Progress Notes for Resident #53, dated 8/27/24 at 2:58 PM, documented the resident was discharged to another facility. On 1/14/25 at 3:00 PM the Administrator stated they did not have a specific policy for MDS assessments and the facility followed regulations. An interview with Staff B on 1/15/25 at 9:12 AM revealed the document was somehow changed to do not submit in the electronic health record. She stated it was probably something she did and acknowledged the MDS should have been submitted. At 9:30 AM an additional interview with Staff B determined she followed the Resident Assessment Instrument (RAI) Manual for processing MDS data.	F 640		

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F 641	Continued From page 5	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, Preadmission Screening and Resident Review form (PASRR) the facility failed to code diagnosis of intellectual deficits (ID) and inaccurately coded for hospice on the Minimum Data Set (MDS) assessments for 2 of 3 residents MDS assessments reviewed (Resident #35, #45). The facility reported a census of 77 residents.

Findings include:

1. The Minimum Data Set (MDS) dated 10/17/24 documented Resident #45 diagnoses included quadriplegia, seizure disorder, malnutrition, pressure ulcers, and unspecified intellectual disabilities. The Brief Interview for Mental Status (BIMS) was not scored, documented the resident was unable to complete the interview. The MDS section labeled PASRR did not code to reveal resident's intellectual disability.

The PASRR form, notice date 10/9/24 relayed Resident #45 approved for 60-day convalescence, had suspected or confirmed PASRR condition that included intellectual disability. The form documented, the PASRR condition must be documented in the MDS. The PASRR form specifically directed to code on the MDS resident's diagnosis of intellectual disability. Review of the MDS indicated lack of completion of both sections directed to be completed.

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F 641	Continued From page 6 The Care Plan focus dated 10/11/24 for Resident #45 documented PASRR baseline, new admission, intervention to follow PASRR recommendations as applicable. The Care Plan focus initiated 10/18/24 documented the resident had impaired cognitive function and impaired thought process related to developmental and intellectual disability. On 1/15/24 at 9:30 AM the MDS Coordinator, Registered Nurse, Staff B relayed they are responsible for completing MDS documents and follow the Resident Assessment Instrument (RAI) Manual for MDS coding. Staff B relayed Resident #45 should have been coded for intellectual deficit. On 1/14/25 at 3:00 the Administrator voiced they do not have a specific policy on MDS completion, relayed they follow the federal mandated process. 2. Review of Resident #35's facility census indicated on 10/10/24 the resident was changed from Hospice private pay to private pay. Review of Resident #35's Significant Change MDS dated 10/29/24 indicated Resident #35 received Hospice services. Review of Resident #35's Physician Order Summary indicated admission to Hospice related to Lewy Body Dementia on 4/16/24 with a discontinue date of 10/9/24. Review of Resident #35's Care Plan indicated on 4/17/24 Hospice Care was required due to a diagnosis of Lewy Body Dementia and resolved on 10/11/24.	F 641		

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F 641	Continued From page 7 Review of Hospice Discharge Summary dated 10/7/24 indicated Resident #35 started Hospice care on 4/16/24 and effective discharge date of 10/9/24 as Resident #35 was determined to no longer meet criteria for hospice care. During an interview on 1/15/25 at 10:10 AM, Staff B, MDS Coordinator, stated the Significant Change MDS completed on 10/29/24 was due to Resident #35 being discharged from Hospice Care. While reviewing the Significant Change MDS, Staff B acknowledged the MDS indicated Resident #35 was receiving Hospice care and stated this was not accurate and needed to be corrected.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or	F 645		

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F 645	Continued From page 8	F 645		

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental

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F 645	Continued From page 9	F 645		

disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and Preadmission Screening and Resident Review (PASRR) form evaluation the facility failed to ensure a re-screen for 1 of 2 residents reviewed in the PASRR sample. Resident #45 exceeded the sixty (60) day convalescent care approval without the required re-screening. The facility reported a census of 77 residents.

Findings include:

The Minimum Data Set (MDS) dated 10/17/24 documented Resident #45 diagnoses included quadriplegia, seizure disorder, malnutrition, pressure ulcers, and unspecified intellectual disabilities. The Brief Interview for Mental Status (BIMS) was not scored, documented resident was unable to complete the interview.

The Care Plan focus dated 10/11/24 for Resident #45 documented PASRR baseline, new admission, intervention to follow PASRR recommendations as applicable. The Care Plan focus initiated 10/18/24 documented the resident had impaired cognitive function and impaired thought process related to developmental and intellectual disability.

The PASRR form dated 10/8/24 documented resident #45 evaluation determined a PASRR

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F 645	Continued From page 10 condition, noted suspected or confirmed PASRR condition that included intellectual disability. Approved for convalescence categorical approval for period of 60 days, expected to discharge within 60 days and If stay goes beyond the nursing facility must submit a status change, required prior to the 60th day. On 1/13/25 at 1:40 PM the Director of Nurses relayed the Social Services, Staff A, was responsible for the initial PASRR and follow up. During an interview on 1/13/25 at 1:45 PM the Social Service, Staff A, revealed they are new to working with PASRR's, acknowledged resident #45 was granted the 60-day approval and should have been reevaluated. On 1/14/25 at 3:00 the Administrator relayed the facility does not have a policy on PASRR completion and follows the regulation.	F 645		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services	F 725		

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F 725	Continued From page 11 by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, staff interviews, and facility reported payroll data the facility failed to provide adequate staffing to meet resident needs. The facility reported a census of 77 residents. Findings include: A document titled PBJ (Payroll Based Journal) Staffing Data Report representing 7/1/24 through 9/30/24 indicated data submitted by the facility triggered for excessively low weekend staffing. The undated Facility Assessment in effect at the time of the PBJ report documented 272 FT Licensed nursing hours per week and 952 nursing assistant hours per week based on an average daily census of 67.3. Page 1 of the assessment noted it was reviewed annually, updated if indicated and whenever there was a significant change in the assessment of the facility including but not limited to changes in facility capacity or services provided.	F 725		

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F 725	Continued From page 12 An interview with Resident #64 (Brief Interview for Mental Status score of 15/15 indicative of intact cognition) on 01/12/25 at 11:04 AM revealed she sat on a bedpan for 'a long time.' A further interview on 01/15/24 at 11:45 AM determined she was left on the bedpan recently for 45 minutes. The resident could not remember the day but thought it might have been the past weekend during the day. When asked what she felt the cause was, Resident #64 stated it was a staffing issue. She reported the staff who were in the facility were great but had to 'run their asses off' because sometimes there were not enough of them to help everyone who needed it. During an interview on 01/13/25 at 02:03 PM the DON stated she thought the facility had enough staff during the weekends. She reported the facility did use more agency staff on the weekend. On 1/14/25 at 12:49 PM the Administrator provided a recap of the daily census for 7/1/24 through 9/30/24 that documented an average daily census of 76.8. He stated the Facility Assessment was not updated during that time, but was updated in November 2024. During an interview on 1/15/25 at 11:07 AM Staff C, Medical Records/Scheduler stated the facility used a matrix on a spreadsheet to determine staffing needed. She reported weekend staffing was the same as weekdays, determined by the number of residents entered. When asked if resident acuity was considered as part of the matrix, she said there was nothing in the spreadsheet for acuity. At 11:20 AM on 1/15/25 Staff D, Certified	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165017	A. BUILDING ______ B. WING ______	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY CEDAR RAPIDS	1940 FIRST AVENUE NE CEDAR RAPIDS, IA 52402

(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 725	Continued From page 13 Medication Aide, stated the most important resident needs were met. When asked if there were enough staff to address all of the resident's care planned needs she said probably not all of them. She stated some residents took longer, had more to take care of, and used lifts that take time and two people. She indicated need depended on census and felt quality of care was important. Staff D also noted the ability to participate in team meetings, care planning meetings, training, and taking time with residents depended on staffing and census. On 1/15/25 at 11:50 AM the Administrator reported the facility had reviewed the data submitted for the PBJ and came up with the same result that indicated low weekend staffing.	F 725		

Harmony Cedar Rapids
1940 1st Ave NE
Cedar Rapids, IA 52402

Provider ID:165017

Plan of Correction for survey completed January 12th, 2025

The statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies by Harmony Cedar Rapids. To remain in compliance with State and Federal regulations, the facility has taken or will take the following actions set forth in this plan of correction.

F578 483.10(c)(6)(8)(g)(12)(i)-(v) Advance Directives

Corrective action taken by deficient practice.

Resident #64 was assisted with updating Advance Directives, ensuring electronic medical record, IPOST and care plan match and are accurate per resident wishes.

How the center will identify the potential of the same deficient practice.

Residents who reside at the facility have the potential to be affected by deficient practice.

What changes will be put into place to ensure that the problem will be corrected and will not recure.

Nurse personal have been re-educated to ensure when completing or updating an Advance Directive for a resident that all areas electronic medical record, IPOST and care plan are updated and match.

Quality assurance plan to monitor performance to make sure corrections are achieved and are permanent.

Nurse management or designee will conduct random audits weekly x4 weeks to ensure documentation for Advance Directive is accurate in electronic medial record, IPOST and care plan.

Identified concerns shall be reviewed by the facility's QAA committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

F640 483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments

Corrective action taken by deficient practice.

Resident #53 was unaffected by late submission of MDS Assessment.

How the center will identify the potential of the same deficient practice.

Residents who reside at the facility have the potential to be affected by deficient practice.

What changes will be put into place to ensure that the problem will be corrected and will not recure.

MDS Coordinator was re-educated on MDS process and timely submission of MDS Assessment and to follow the Resident Assessment Instrument (RAI) Manual for Processing MDS data.

Quality assurance plan to monitor performance to make sure corrections are achieved and are permanent.

Director of Nursing and or designee will audit the MDS portal weekly x4 weeks to ensure MDS assessments are transmitted within the guidelines of RAI manual.

Identified concerns shall be reviewed by the facility's QAA committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

F641 483.20(g) Accuracy of Assessments

Corrective action taken by deficient practice.

Resident #35 and #45 who had inaccurate coding submitted on MDS Assessment; MDS Coordinator completed a correction MDS Assessment, for both residents correcting resident information within the MDS Assessment and resubmitting with accurate information of residents.

How the center will identify the potential of the same deficient practice.

Residents who reside at the facility have the potential to be affected by deficient practice.

What changes will be put into place to ensure that the problem will be corrected and will not recure.

MDS Coordinator was re-educated on MDS process and MDS Assessment and to follow the Resident Assessment Instrument (RAI) Manual along with reviewing the recommendations within a resident's PASRR.

Quality assurance plan to monitor performance to make sure corrections are achieved and are permanent.

Director of Nursing and or designee will audit the MDS for accuracy of diagnosis and/or support services such as hospice weekly x4 weeks to ensure MDS coding is accurate.

MDS Coordinator will routinely ensure accurate coding upon completion of an MDS Assessment prior to submission and to review thoroughly an individuals PASARR upon admission and coding within the MDS Assessment PASARR recommendations and as needed thereafter to observe compliant practice.

Identified concerns shall be reviewed by the facility's QAA committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

F645 483.20(k)(1)-(3) PASARR Screening for MD & ID

Corrective action taken by deficient practice.

Resident #45 PASARR was re-evaluated and submitted within the Service Matter portal for review.

How the center will identify the potential of the same deficient practice.

Residents who reside at the facility have the potential to be affected by deficient practice.

What changes will be put into place to ensure that the problem will be corrected and will not recure.

Social Services Coordinator re-educated on PASARR process and timely re-evaluation of PASARR to meet residents needs.

Quality assurance plan to monitor performance to make sure corrections are achieved and are permanent.

Social Service or designee will audit PASARR Service Matter portal weekly x4 weeks, then monthly x2 months to ensure PASARR re-screens are completed, as indicated.

Social Services will routinely ensure to review Service Matter portal and update and re-evaluate PASARRs as indicated within the Service Matter Portal to observe compliant practice.

Identified concerns shall be reviewed by the facility's QAA committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.

F725 483.35(a)(1)(2) Sufficient Nursing Staff

Corrective action taken by deficient practice.

Facility assessment was reviewed and corrected to reflect current needs and sufficient staffing related to patient care needs.

How the center will identify the potential of the same deficient practice.

Residents who reside at the facility have the potential to be affected by deficient practice.

What changes will be put into place to ensure that the problem will be corrected and will not recure.

Administrator was educated on the process of updating the Facility Assessment to reflect current needs and sufficient staffing related to patient care needs.

Quality assurance plan to monitor performance to make sure corrections are achieved and are permanent.

Administrator will complete audits monthly x4 months of Facility Assessment to observe complaint practice.

Identified concerns shall be reviewed by the facility's QAA committee. Recommendations for further corrective action will be discussed and implemented to sustain compliance.