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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 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 [DATE] 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. The Care Plan revealed a focus initiated [DATE] 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 [DATE] 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 [DATE]. During an interview on [DATE] 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 48452 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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 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 [DATE] 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. 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. 49698 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 [DATE] 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. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Hospice Discharge Summary dated 10/7/24 indicated Resident #35 started Hospice care on 4/16/24 and effective discharge date of [DATE] 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.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 48452 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. 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 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.