STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165081	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Village Retirement	600 Park Lane Waterloo, IA 50702

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review and staff interview the facility failed to accurately code 1 of 16 residents Minimum Data Set (MDS) accurately (Resident #59). The facility reported a census of 66 residents. Findings include: Record review of Resident #59 MDS dated [DATE] documented she had a fall with major injury (bone fractures, joint dislocation, closed head injury with altered consciousness, and subdural hematoma) while living at the facility. On 10/9/2024 at 11:36 AM the Administrator reported the facility coded Resident #59's fall with major injury in error and they would fix it. Record review of Resident #59's MDS dated [DATE] with an attestation date of 10/9/24 listed the reason for modification as an item coding error.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on clinical record review, document review and staff interview, the facility failed to complete a new level 1 Preadmission Screening and Resident Review (PASRR) screening for 1 of 1 resident's sampled (Resident #19). The facility identified a census of 66 residents. Findings include: Resident #19's Electronic Admission Record listed an admitted [DATE]. Resident #19's PASRR screening dated 8/28/23 documented the following: a. Diagnoses - no mental health diagnoses is known or suspected and no dementia/neurocognitive disorders. b. Behaviors and Symptoms - no known mental health behaviors which affected interpersonal interactions; no known mental health symptoms affecting the individual's ability to think through or complete tasks which she/he should be physically capable of completing; no known recent or current mental health symptoms. c. Services and Other Indicators - no, individual has not received mental health services now or in the past. d. Mental Health Medications - no medications listed. The PASRR documented no level two required as of 8/28/23. The Care Plan Category dated 9/14/23 reflected Resident #19 had a Behavioral Problem. The Care Plan indicated Resident #19 had a risk for behavioral disturbance related to signs and symptoms of anxiety, calling out for help, needing additional staff presence, support, and delusions. At times may display aggressive behavior toward others. A family member reported attention seeking behaviors. The Care Plan directed the following: a. 9/14/23: Staff to provide orientation to Resident #19 during times of confusion, anxiety, and delusional thinking b. 9/14/23: Attempt reality orientation during times of delusions. c. 10/16/23: Aggressive behavior toward another resident. Staff provide one to one supervision as needed. The Care Plan Category dated 9/29/23 identified Resident #19 received high risk antipsychotic medication related to behaviors with delusions. The Care Plan directed the following dated 9/29/23: a. Administer the medication per the physician order (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Monitor for medication side effects. c. Perform an abnormal involuntary movement scale (AIMS, a test to monitor for side effects of long-term use of antipsychotic medications) assessment every 3-6 months; d. Monitor for desired effect of the medication e. Provide gradual dose reductions per the pharmacy recommendations. The Care Plan Category dated 10/11/23 outlined Resident #19 received high risk antianxiety medications. The Intervention directed to monitor the use of the medication. Resident #19's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS indicated Resident #19 had other behaviors not directed toward others (examples physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing, throwing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds) occurring 1-3 days per week. The MDS included a diagnosis of hypertension (high blood pressure). Resident #19 used antipsychotic, antianxiety and antidepressant medications during the lookback period. Resident #19's MDS assessment dated [DATE] identified a BIMS score of 5, indicating a severely cognitively impaired. The MDS lacked documentation of signs of delirium or behaviors. The MDS included diagnoses of hypertension and psychotic disorder. The MDS indicated Resident #19 received antipsychotic medication during the lookback period. The Quarterly MDS assessment dated [DATE] showed a BIMS score of 10 indicating a moderate cognitive loss. The MDS indicated Resident #19 did not exhibit signs of delirium, mood or behavioral symptoms. The MDS included diagnoses of stroke, hypertension, and psychotic disorder. Resident #19 used antipsychotic medication during the lookback period. A 4/3/24 Neuropsychiatry Progress Note documented Resident #19's visit due to a chief complaint of a primary diagnosis of mood disorder, anxiety, and psychosis in the elderly. Resident #19 had a behavior disturbance and used a medication order for Risperidone 1 MG tablet by mouth twice a day and Trazodone 25 milligrams (MG) by mouth nightly. An 8/5/24 Nurse Practitioner Note documented Resident #19 had diagnoses of dementia and being a poor historian. Further clinical record review showed Resident #19 didn't receive their diagnosis of dementia until the 8/5/24 visit. A 10/7/24 review of Resident #19's clinical record revealed the following physician orders since admission: a. 9/15/23: Physician Order request for psychiatric consult due to increased confusion, hallucinations, and anxiety. b. 9/22/23: signed Physician Order for Haldol (antipsychotic medication) 2.5 MG by mouth one time only. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Pharmacist Recommendation to Prescriber 9/22/23 for clinical rationale to continue as needed lorazepam (antianxiety) 0.5 MG written effectively treats anxiety. d. 10/6/23: signed Physician Order for Trazodone (antidepressant medication) 25 MG by mouth every hour of sleep (HS or bedtime). e. 10/11/23: Physician Order to increase Risperidone (antipsychotic medication, brand name Risperdal) 0.5 MG by mouth twice a day for a diagnosis of mood disorder. f. 10/25/23: signed Physician Order for Risperdal (antipsychotic medication) 1 MG by mouth twice a day. f. 10/25/23: Physician Order Sheet and Progress Note with documentation of new diagnosis for psychosis in the elderly with behavioral disturbance. A 10/9/24 Physician Visit Note documented the reason for visit as diagnoses of mood disorder (primary), anxiety, and psychosis in the elderly with behavioral disturbance. The Note listed a current physician order for Risperdal 1 MG by mouth two times a day. The Note included the diagnoses of anxiety and psychosis in the elderly with behavioral disturbance as a current diagnosis since 9/15/23 and the diagnosis of mood disorder current since 10/11/23. During an interview on 10/9/24 at 10:20 AM the Social Worker, reported she would re-screen the PASRR if the resident had an in-patient psychiatric hospital stay, which they didn't have any, or if the resident received a new psychiatric diagnosis. On 10/9/24 at 1:16 PM the Social Worker verbalized she updated the PASRR assessment that day and had a pending review at the time. She reviewed the 4/3/24 Psychiatric Visit note highlighting the chief complaint as seeing Resident #19 for mood disorder, anxiety, and psychosis in the elderly with behavioral disturbance. She verbalized agreement someone should have updated the PASRR in September/October 2023 when they started seeing Psychiatry. During an interview on 10/9/24 at 2:55 PM the Administrator and Director of Nursing both verbalized they expected the staff to follow the facility policy. In addition, they expected the staff to re-screen a resident to be re-screened for PASRR when a new psychiatric diagnosis is written. The PASRR Policy and Procedure, dated August 2023, directed if a resident experienced a new mental illness diagnosis, the PASRR will be updated.