STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165197	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Falls Health Care Center	1728 West Eighth Street Cedar Falls, IA 50613

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35438 Based on record review, staff and family interview on 7/15/24 the facility failed to make the required notifications for residents for 2 of 5 residents reviewed (Residents #5 and #6). The facility failed have an updated condition report list to accurately notify the family/resident representative of an acute transfer and hospital admission for Resident #6. In addition, the facility failed to notify the physician when the facility didn't have medications to give Resident #5 the night of her admission to the facility. The facility identified a census of 35 residents. Findings include: 1. Resident #6's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicated intact cognition. The MDS listed Resident #6 as independent for bed mobility and partial to moderate assistance for transfers. The MDS included diagnoses of traumatic subdural hematoma (injury to the brain) and a seizure disorder. A progress note dated 7/15/24 at 10:32 AM written by Staff A, Registered Nurse (RN), indicated they received an order to send Resident #6 to the local emergency room for an evaluation and treatment. The note reflected Staff A left a message with the family. In an interview on 8/12/24 at 3:10 PM Resident #6's family member verified the facility didn't notified them when Resident #6 transferred to the hospital and/or his admission to the hospital. The family member stated the facility informed her they tried to reach her, however, the facility had the incorrect number on file for. The family member stated the family expected the facility to contact them so Resident #6 wouldn't have been alone when he passed. During an interview on 8/14/24 at 1:00 PM a second family member of Resident #6 stated she didn't receive a call from the facility even though she is the medical power of attorney. She expected the facility to notify her. The family member said she reviewed her incoming call log and said she didn't have any calls from the facility. The family member reported the facility did call her on 7/13/24 about another matter. (continued on next page)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/13/24 at 1:00 PM Staff A stated he called the first contact number on the condition report of the admission record, after his assessment identified a change of condition for Resident #6 that required transfer to the hospital. Staff A clarified he didn't get an answer and he left a message for the family to call related to a condition change. Staff A denied trying any other numbers on the condition report. Staff A added he expected the information to be correct, however, he learned later the clinical record had incorrect contact information. Staff A explained the facility expected the staff to notify the family or emergency contact when a resident had a condition change. In an interview on 8/13/24 at 12:20 PM the Director of Nursing (DON) reported on 7/15/24 when Resident #6 had a change of condition, Staff A called Resident #6's #1 contact. When they didn't answer, he left a message. The DON added the next day Resident #6 passed away at the hospital. The family became very upset, and explained no one contacted them and Resident #6 passed away without his family knowing about his hospitalization , so they couldn't be with him. Her investigation determined when Resident #6 originally admitted to the electronic record system on 8/14/17. As Resident #6 returned to the facility as a re admission, the staff didn't verify his contacts information. Due to this Resident #'6's clinical record had an incorrect number. The DON reported they expected the facility to notify the resident's family or emergency contact their change of condition, falls, medication change, or transfer out of facility. 2. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] listed an admitted [DATE] from a short-term hospital. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of orthopedic aftercare, hypertension (high blood pressure), muscle weakness. and severe obesity. Resident #5's June 2024 Medication Administration Record (MAR) included the following orders dated 6/27/24: a. Clonazepam 0.25 milligrams (MG) daily for anxiety at HS (hour of sleep). - The documentation indicated the facility held the 6/27/24 and 6/28/24 doses. b. Famotidine 20 MG twice a day (BID) for reflux with a start date of 6/27/24. - The documentation indicated the facility held the 6/27/24 HS dose. c. Metoprolol 25G BID (twice a day) for hypertension. - The documentation indicated the facility held the 6/27/24 HS dose d. Hydroxyzine 25 MG TID for anxiety. - The documentation indicated the facility held the 6/27/24 HS dose. e. Methocarbamol 750 MG four times a day for muscle spasms. - The documentation indicated the facility held the 6/27/24 Evening and HS dose. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an electronic progress note dated 6/27/24 at 8:44 PM Staff B, Registered Nurse (RN), documented the facility didn't have Resident #5's medications at that time. The clinical record lacked notification to the physician. In an interview on 8/13/24 at 12:20 PM the Director of Nursing (DON) stated the facility couldn't find documentation related to notifying the provider that Resident #5 didn't receive her medications ordered upon admission. The DON expected the staff to notify the provider if they couldn't administer the medications as ordered. A nursing policy and procedure titled Medication Variance Guideline defined the policy as to assist in reducing medication administration errors and the steps to follow when an error occurred. The policy instructed after a medication error, recognize an error has been made, evaluate the patient's condition, or reaction to the medication error, report to immediate supervisor, notify the physician, and document the physician's response.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35438 Based on record review, staff interview, and facility policy review the facility failed to following medication administration protocols for a new admission resident to the facility. The facility failed to provide medications as ordered on admission for 1 of 4 residents reviewed (Resident #5). The facility reported a census of 35 residents. Findings include: 1. Resident #5's Minimum Data Set (MDS) assessment dated [DATE] listed an admitted [DATE] from a short-term hospital. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of orthopedic aftercare, hypertension (high blood pressure), muscle weakness. and severe obesity. Resident #5's June 2024 Medication Administration Record (MAR) included the following orders dated 6/27/24: a. Clonazepam 0.25 milligrams (MG) daily for anxiety at HS (hour of sleep). - The documentation indicated the facility held the 6/27/24 and 6/28/24 doses. b. Famotidine 20 MG twice a day (BID) for reflux with a start date of 6/27/24. - The documentation indicated the facility held the 6/27/24 HS dose. c. Metoprolol 25G BID (twice a day) for hypertension. - The documentation indicated the facility held the 6/27/24 HS dose d. Hydroxyzine 25 MG TID for anxiety. - The documentation indicated the facility held the 6/27/24 HS dose. e. Methocarbamol 750 MG four times a day for muscle spasms. - The documentation indicated the facility held the 6/27/24 Evening and HS dose. Review of an electronic progress note dated 6/27/24 at 8:44 PM Staff B, Registered Nurse (RN), documented the facility didn't have Resident #5's medications at that time. In an interview on 8/13/24 at 12:20 PM the Director of Nursing (DON) stated the facility couldn't find documentation related to notifying the provider that Resident #5 didn't receive her medications ordered upon admission. The DON expected the staff to notify the provider if they couldn't administer the medications as ordered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing policy and procedure titled Medication Variance Guideline defined the policy as to assist in reducing medication administration errors and the steps to follow when an error occurred. The policy defined an error as any preventable event that may cause or lead to inappropriate medication use while the medication is in the control of the health care professional. Actions to take following a medication error included: recognize an error has been made, evaluate the patient's condition or reaction to the medication error, report to immediate supervisor, notify the physician, and document the physician response.