STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165340	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Healthcare Center	800 Fifth Street SE Oelwein, IA 50662

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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 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42134 Based on clinical record review, Long Term Facility Resident Assessment Instrument 3.0 User's Manual version 1.18.1 Dated October 2023 (RAI), and staff interview the facility failed to complete Significant Change in Status (SCSA) Minimum Data Set (MDS) assessments in the required time frame for 2 of 2 residents reviewed for hospice (Residents #22 and #29). The facility reported a census of 51 residents. Findings include: 1. Physician orders for Resident #22 included an order to refer to hospice dated 4/29/24. The MDS dated [DATE] was coded as a significant change assessment for hospice services. The MDS was signed off as complete on 5/21/24, 21 days after the determination of a significant change. The RAI Page 2-17 directs the MDS completion date is no later than the 14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days). Page 2-25 directs An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. During an interview on 7/2/24 at 12:14 PM Staff G, Resident Care Coordinator, explained they do not have an MDS policy. She further explained they use the RAI for direction. She confirmed the hospice order date and the MDS completion date. 42133 2. The Electronic Census documented Resident #29 admitted into hospice care services on 6/11/24. A Hospice Election Statement dated 6/11/24 showed the family signed Resident #29 into hospice care. A 7/01/24 review of the MDS 3.0 Summary Page showed a Significant Change in Status MDS assessment with an assessment reference date of 6/21/24. The MDS 3.0 Summary page showed section V Care Area Assessment highlighted in yellow documenting in progress. The Complete MDS box highlighted in yellow directed to complete the MDS by 7/05/24. The MDS had not been signed, finalized, and locked to show completion of the assessment in the required time frame by 6/24/24 (14 days). (continued on next page)

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

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 7/02/24 at 2:49 PM Staff G verbalized she didn't understand the time requirements regarding the significant change completion date from the date of determination regarding hospice care from the RAI manual

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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 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** 42134 Based on clinical record review, Long Term Facility Resident Assessment Instrument 3.0 User's Manual version 1.18.1 Dated October 2023 (RAI), and staff interview the facility failed accurately complete the Minimum Data Set (MDS) for 3 of 5 residents (Residents #5, #8 and #45). The facility failed to accurately code anticoagulant medications and Pre-Admission Screening and Resident Reviews (PASRR). The facility reported a census of 51 residents. Findings include: The MDS dated [DATE] for Resident #45 documented the resident was taking anticoagulant medication. The physician orders lacked an order for an anticoagulant medication. The orders did include an order for clopidogrel, an antiplatelet medication. During an interview on 7/1/24 at 2:10 PM Staff I, Registered Nurse (RN), Co- Director of Nursing (DON) confirmed there was no anticoagulant medication ordered for the resident. The RAI page 1-4 documents the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR (Code of Federal Regulations) 483.20 (b)(1)(xviii), (g), and (h) require that the assessment accurately reflects the resident's status. During an interview on 7/2/24 at 12:14 PM Staff G, RN Resident Care Coordinator, explained they do not have an MDS policy. She further explained they follow the RAI. She continued to explain they have an MDS Drug Class Index they use for medications. She confirmed the guide listed clopidogrel as an antiplatelet medication and it should not have been coded as an anticoagulant. 42133 2. Ascend Management Innovations (Ascend) is under contract with the Iowa Department of Human Services, Mental Health and Disability Services, to perform PASRR evaluations. PASRR evaluations are federally required to help decide upon the best placement and services for persons who have disabilities. The 1/17/19 PASRR for Resident #5 under Mental Health documented Resident #5 met the criteria for having a diagnosis of mental illness as defined by PASRR. The PASRR included an Axis 1 primary diagnosis of schizoaffective disorder, bipolar type. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #5 Annual Minimum Data Set (MDS) assessment dated [DATE], under Section A 1500 Level II PASRR for the question is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition was marked no. The MDS Section Z0400 Signature of Persons Completing the Assessment contained the following statement: I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf. Staff A Social Worker at Z0400 signed she completed section A on 2/13/24. On 7/02/24 at 12:38 PM Staff G explained Section A of the MDS is usually completed by the Social Worker and the MDS Coordinator. During an interview on 7/02/24 at 12:40 PM Staff A reported she reviews the PASRR document from Ascend. If the PASRR is a level II and marked for a mental illness, she would mark yes on the MDS (at A 1500). Staff A reviewed the MDS and confirmed she had not completed section A1500 correctly. Staff A reported the facility utilizes the RAI (manual) to code the MDS. The MDS RAI User manual, Chapter 3, page A-32 directs to code 1, yes if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. The services to be provided by the nursing home and/or specialized services provided by the State that are specified in the Level II PASRR determination and the evaluation report should be addressed in the plan of care. 3. The 9/11/15 PASRR under Mental Health documented Resident #8 met the criteria for having a diagnosis of mental illness as defined by PASRR. The PASRR included an Axis 1 Primary Diagnosis of bipolar I disorder single manic episode and Axis I Secondary Diagnosis as major depressive disorder, single episode/severe/psychotic features. Resident #8 Significant Change in Status (SCSA) MDS dated [DATE], under Section A 1500 Level II PASRR for the questions is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition was marked no. Section I documented a diagnosis of bipolar disorder, but lacked documentation of major depression. The MDS 3.0 Section A - Identification Information page showed Staff A signed A1500, Level II PASRR conditions as completed on 1/23/24.

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F 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 41537 Based on record review, staff interviews, and policy review the facility failed to ensure 2 of 4 residents Pre-admission Screening and Resident Review (PASRR) was submitted for review (Residents #19 and #22). Resident #19 was approved for a short term 60 day stay in 2018 and new diagnoses were documented in her medical record the facility failed to resubmit for review of needed services. The facility failed to accurately complete the PASRR for Resident #22 prior to admission, omitting diagnoses and medications. The facility reported a census of 51 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #19 dated 8/10/2023 documented a Brief Interview for Mental Status (BIMS) of 13 indicating she was cognitively intact. The MDS documented diagnoses of depression, psychotic disorder, and paranoid schizophrenia. Review of a document titled, Notice of Level of Care Determination Criteria Met for Short Term Stay at Skilled Nursing Facility dated 4/17/2018 for Resident #19 documented she was approved for 60 days and needed to be resubmitted by 6/16/2018. During an interview on 7/2/24 at 1:50 PM with Staff A, Social Worker, Staff H, Licensed Practical Nurse (LPN), and the Administrator revealed they did not know about Resident #19 Short Term 60 day stay PASRR. Staff A on 7/3/24 at 10:22 AM revealed they received Resident #19 new PASRR and was dated 7/3/24. Review of a policy provided by the facility titled Baseline Care Plan Guidelines last revised 12/10/2018 instructed to the facility to implement PASRR recommendations, if applicable into the Care Plan. 42134 2. The admission MDS dated [DATE] for Resident #22 documented an admitted [DATE]. The Electronic Health Record (EHR) medical diagnoses included major depressive disorder and psychotic disorder with delusions, both noted as present on admission. The Physician Orders in the EHR included quetiapine (an antipsychotic medication), Namenda (for dementia) and lorazepam (an antianxiety medication) all ordered on admission. The PASRR Level 1 completed on 8/31/23 for Resident #22 was coded with no mental health diagnosis being known or suspected. Medications included on the PASRR were lorazepam and Namenda. During an interview on 7/2/24 at 1:47 PM Staff H, LPN explained she does not check PASRRs for accuracy with diagnoses and medications.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on clinical record review, document review, policy review, and staff interview the facility failed to serve the correct puree portion size for 2 of 6 residents sampled (Resident #26 and #19). Resident #26 and #19 were both documented as significant weight losses in the past six months (a significant weight loss is a 10% or greater weight loss in 6 months). The facility identified a census of 51 residents. Findings include: 1. Resident #26 Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 99 indicating severe cognitive loss, with long and short-term memory impairment. Resident #26 could not recall the current season, location of his room, or staff names and faces. The MDS listed diagnoses of Non-Alzheimer's Dementia, unspecified psychosis, and required supervision or touching assistance (the helper sets up or cleans up; resident completes the activity. The helper assists only prior to or following the activity) for eating. The MDS documented Resident #26 with a significant weight loss (a significant weight loss is defined as a loss of 5% or more in the last month or loss of 10% or more in last 6 months) and receiving a mechanically altered diet (a required change in texture of food or liquids (e.g., pureed food, thickened liquids). Section K0300 Weight Loss, signed as complete on 5/28/24 by the contracted Dietician, for significant weight loss documented, Yes, not on a prescribed weight loss regimen. Resident #26 Medication Order Review signed by the Provider on 4/02/24 listed a physician order for a pureed texture general diet. Resident #26 Weight Summary Record documented the following weights: a. 11/16/24 231.4 pounds (#) b. 5/15/24 209.8# (weight on 5/21/24 MDS assessment) c. 6/26/24 206.5# (weight loss 24.9#) A 6/28/2024 12:40 PM Significant Weight Change Progress Note documented a weight warning with a weight of 206.5# as of 6/26/24 with an MDS significant weight change of 11.4% weight loss in 180 days. The Progress Note lacked documentation of new interventions placed for Resident #26 weight loss. 2. Resident #19 MDS assessment dated [DATE] showed a BIMS score of 9 indicating moderate cognitive loss. The Resident required setup/clean up assistance with eating. The MDS listed diagnoses of aphasia and paranoid schizophrenia. The MDS documented Resident #19 required a mechanically altered diet and a therapeutic diet. Resident #19 Medication Review Report signed by the Provider on 6/25/24 ordered to serve a general pureed texture diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #19 Weight Summary Record documented the following weights: a. 12/28/23 264.5# b. 6/27/24 231.1# (weight loss 33.4#) A 6/28/2024 10:22 AM Significant Weight Change Progress Note documented a weight warning with a 6/27/24 weight of 231.1 pounds. The Progress Note noted a 11.9% weight loss over 180 days. A week 4 Monday Menu approved by the corporate registered dietician 7/01/24 listed the main entree for the lunch pureed diet menu as 1 serving of a grilled ham and cheese sandwich. The Diet Type Report provided by the facility on 6/30/24 identified six residents on physician ordered pureed diets (Residents #2, #19, #26, #39, #42, and #46). A Pureed Diet is a texture-modified eating plan that consists of foods with a soft, pudding-like consistency. It's often recommended for people who have difficulty chewing or digesting solid foods, such as those with difficulty swallowing or other digestive issues. The goal of a pureed diet is to prevent malnutrition by making a variety of foods safe to eat. During an observation on 7/01/24 at 9:28 AM Staff B, [NAME] reported she would prepare six servings of the ham and cheese sandwich as she had six residents on pureed diets. Staff B placed six ham and cheese sandwiches into the Robo Coupe blender. Staff B continued to add milk to obtain a puree consistency. The total puree food volume measured 6 3/4 cups of a very thin pureed product. Staff B utilized the Pureed Diet Portion Sizes/Scoops, Total Cups of Pureed Food chart to obtain a correct serving size for each resident. The Chart directed to find the number of persons that you pureed food for along the left-hand column of the table, then find the total cups of pureed food that you prepared along the top row of the chart. Follow both the row and column to where they meet and you will find the correct scoop to portion for the pureed food item. Staff B identified the six servings in the left-hand column and the total volume of puree along the top of the chart. She followed the chart to get a serving size of A #8 scoop x 2 (indicating to serve two of the #8 scoop) and a #30 scoop. Staff B located the #8 and the #30 scoop and set up for the dietary aide to serve. On 7/01/24 at 11:55 AM Staff C, walked to the steam table, reached in and picked up the #8 (4 ounce) scoop and placed 1 scoop of the pureed ham and cheese sandwich puree into a red bowl for Resident #26. Staff C failed to serve the second #8 scoop per the puree chart. The black #30 scoop (1 ounce) lay right next to the gray handled # 30 scoop, but was not utilized. Staff C then placed one #8 scoop serving of the pureed ham and cheese sandwich for another resident, who was not included in the sample. Observation on 7/01/24 at 11:56 revealed Staff D, Dietary Aide grabbed the #30 scoop and put one scoop of the pureed ham and cheese into a bowl that was served out to Resident #19. At 11:57 Staff C placed Resident #26 lunch and another random resident's lunch on a cart and wheeled the cart to A wing to serve the meals. At 12:04 PM Staff C returned the meal cart from A wing to the kitchen. The #30 scoop lay unused next to the steam pan of pureed ham and cheese sandwich on the steam table. At 12:05 PM the black scoop fell down inside the steam table well. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/01/24 at 12:53 PM Staff D reported she had only utilized one (#8) scoop serving size to serve out the pureed ham and cheese sandwiches. She did not use the #30 scoop. Observation revealed the steam pan of pureed ham and cheese sandwich with a half inch of dried puree at all four corners of the steam pan with a 1/2 inch of the puree in the bottom of the pan and over a 1/2 of the mixture still in the #8 scoop. During an observation on 7/01/24 at 12:15 PM Resident #26 finished the last bite of his pureed ham and cheese sandwich from the red bowl. Resident #26 continued to scrape the empty red bowl and lick his spoon repeatedly. Staff E, Certified Nursing Assistant (CNA) looked at Resident #26 and verbalized, Oh! You're all done. The resident continued to scrape his empty red bowl and lick his empty spoon a few more times. The Staff did not offer him more of the pureed ham and cheese sandwich. Observation on 7/01/24 at 12:17 PM revealed Resident #19 had eaten 100 percent (%) of her pureed ham and cheese sandwich. The bowl was scraped clean. On 7/01/24 at 12:46 PM Staff B reported she communicates to the serving dietary aide (Staff D) the scoop sizes that are required after she purees the food. She lays out the scoops for the dietary aide to use. Staff B visualized the #30 scoop laying inside the steam table, reporting and nodding the #30 scoop had not been used. Staff B went to the pureed serving size chart and reviewed the serving for six servings with 6 3/4 cups total volume of the pureed ham and cheese sandwich and voiced the serving size was two of the #8 scoops and one of the #30 scoop. She verbalized only the #8 scoop had been utilized. The facility failed to serve Resident #26 and #19 over a 1/2 cup portion (0.625 cup) of the required entree serving. During an interview on 7/01/24 at 12:48 PM Staff F, Dietary Aide reported she expected the staff to serve the correct pureed portion size according to the Pureed Diet Portion Size/Scoop Total Cups of Pureed Food Chart. During an interview on 7/01/24 at 12:49 PM the Certified Dietary Manager (CDM) reported she has talked with Staff C and Staff C admitted she had only given Resident #26 one (#8) scoop of the pureed ham and cheese sandwich. She admitted she had not followed the appropriate serving size. The Procedure for Determining Portion size of Puree Foods, undated, provided by the facility directed the following: 1. Review the recipe and/or spreadsheet to verify the portion required for the regular portions. 2. Prepare the liquids to be used during the puree process. 3. Verify the number of residents requiring a puree diet and plan for one extra portion. 4. Sandwiches: puree the entire sandwich with condiments together or layered pureed bread, puree protein, and puree bread can be made also. 5. Puree food without added liquid at first and add liquid gradually so that the Robo Coupe can work naturally to blend up food. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Measure the total volume of the final pureed product and divide by the number of servings added (including the extra).