

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER St Luke's Helen G Nassif Transitional Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1420 Unitypoint Way 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)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133</p> <p>Based on clinical record review, policy review, family and resident interviews, the facility failed to address the Baseline Care Plan with the resident or the resident's legal representative for 1 of 1 resident's sampled (Resident #1). The facility identified a census of 28 residents.</p> <p>Findings include:</p> <p>The Electronic Medical Record (EMR) Census documented Resident #1 admitted to the facility on [DATE].</p> <p>The Baseline Care Plan documented Staff A, Minimum Data Set (MDS) Coordinator completed the Baseline Care Plan on 2/23/24. The Resident and Resident Representative Signatures Lines were blank on the Care Plan form and there were no notations stating the Baseline Care Plan had been reviewed with the resident or family.</p> <p>Resident #1's MDS assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating a moderate cognitive loss.</p> <p>A review of the Progress Notes from 2/22/23 to 3/05/24 lacked documentation the resident or the resident's representative received a copy of the Baseline Care Plan or that the facility had reviewed the Baseline Care Plan with them.</p> <p>An interview with a family member on 4/16/24 at 4:40 PM reported she never received a copy of the Baseline Care Plan nor was the Baseline Care Plan discussed with her.</p> <p>During an interview on 4/18/24 at 9:18 AM Staff A, MDS Coordinator explained she completes the Baseline Care Plan electronically on the computer. The facility had been using a paper form prior to her taking the position. She does not do anything with the Care Conference and does not attend the Care Conferences. She believes that when the Care Conference is held, a copy of the Baseline Care Plan is given to the resident or legal representative to sign by the Director of Nursing (DON).</p> <p>(continued on next page)</p>

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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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/18/24 at 9:40 AM Staff B, MDS Coordinator verbalized when a resident admitted to the facility she would complete the Baseline Care Plan the day of admission or the next day using a paper form. She then gave the Baseline Care Plan to the DON. She never attended the Care Conferences. The DON would take care of taking the Baseline Care Plan to the Care Conference and go over it with the resident or the family and have one of them sign to acknowledge that the Care Plan had been reviewed with them. After the Baseline Care Plan was signed, the DON would give the Care Plan back to her to put in a binder at the nurse's station. Their practice was to have the resident or the family sign to acknowledge that the Baseline Care Plan had been reviewed with them. If the resident couldn't sign the Baseline Care Plan, they would have a family member sign it or go over the Baseline Care Plan by phone with the family, then the DON would document she went over the Baseline Care Plan with the family on the form.</p> <p>During an interview on 4/18/24 at 10:43 AM the DON reported the Baseline Care Plan starts on a paper form the day of admission. If the resident has a lower BIMS score, then they talk to the family either at the Care Conference or they call the family to review the Baseline Care Plan. She expects the Baseline Care Plan to be gone over with the resident if capable. If not, then the Baseline Care Plan should be reviewed with the family. She verbalized the review should be completed and documented either on the Baseline Care Plan or in the EMR.</p> <p>On 4/18/24 at 11:53 AM the DON reported she had reviewed the documentation and could not find where they had gone over the actual Baseline Care Plan with the resident or the family and that should have been done.</p> <p>The Baseline Care Plan Policy revised 5/15/2019 directed a written summary of the Baseline Care Plan must be provided to the resident and their representative in a manner they can understand. The documentation must be present in the medical record stating the Care Plan was shared with the resident and their representative.</p>		