STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165418	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Simpson Memorial Home	1000 North Miller Street West Liberty, IA 52776

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. Based on clinical record review, facility policy review and staff interviews, the facility failed to notify the physician or their designee of significant weight loss for 1 of 1 residents reviewed for nutrition (Resident #17). The facility reported a census of 32. Findings include: The Minimum Data Set (MDS) Assessment completed 9/5/25 revealed Resident #17 with a Brief Interview for Mental Status score of 12, indicating moderate cognitive impairment. Diagnoses include chronic respiratory failure with hypoxia (low oxygen), chronic obstructive pulmonary disease, and heart failure. The Care Plan with a target date of 12/12/25 identified Resident #17 with an altered nutritional status related to poor appetite and progressive weight decline. Interventions initiated on 9/12/23 include referral to the medical doctor or Registered Dietitian (RD) as necessary. The Weight Change Progress Notes, completed by the RD revealed, in part: 1.On 1/7/25 at 3:50 PM .a significant weight loss was identified at 30 days .2.On 7/5/25 at 10:19 AM .a significant weight loss was identified at 90 days .3.On 10/6/25 at 7:14 PM . a significant weight loss was identified at 180 days .4.On 11/4/25 at 9:20 AM .a significant weight loss was identified at 180 days .Review of the electronic health record (EHR) lacked documentation of physician notification of the above significant weight changes. Review of the Physician Long-term Care Facility/Home Visit Notes dated 1/16/25 and 7/10/25 did not address the identified significant weight loss. During an interview on 12/3/25 at 2:00 PM, the Director of Nursing (DON) stated there is no formal process for physician notification related to significant weight changes. These are typically addressed during a resident's regulatory 60-day physician visit. If or when the physician is notified, this should be documented in the EHR. During an interview on 12/3/25 at 2:15 PM, the RD explained resident weights are reviewed during scheduled weekly facility visits. Identified significant weight changes are forwarded to the administrative nursing staff. The RD noted they do not notify the physician of these changes. The policy Weight Assessment and Intervention, revised March 2022 noted the following: 1.Resident weights are monitored for undesirable or unintended weight loss or gain2.The physician and the multidisciplinary team identify conditions and medication that may be causing anorexia, weight loss or increasing risk of weight loss

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 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** Based on clinical record review, the Resident Assessment Interview Manual, and staff interviews, the facility failed to accurately complete a Minimum Data Set assessment for 3 of 12resident's reviewed in the sample (Residents #6, #9 and #20). The facility reported a census of 32 residents.Findings include:1. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had diagnoses of Non-Alzheimer's Dementia, bipolar disorder and anxiety disorder. The MDS (under section A1500) documented the resident not currently considered by the state level II PASRR (Preadmission Screening and Record Review, a review to prevent inappropriate placement and ensure people with mental illness or an intellectual disability receive the most suitable care) process to have a serious mental illness and/or intellectual disability or a related condition. The Care Plan initiated 3/15/22 and revised 6/18/25 revealed the resident had diagnoses of bipolar disorder, depression, and anxiety disorder. The resident took bupropion (anti-anxiety medication) and Seroquel (an antipsychotic medication) for management of her symptoms. The PASRR dated 5/17/17 revealed the resident's diagnoses of bipolar disorder and depression. The PASRR also indicated a Level II evaluation not required due to the primary diagnosis of dementia. 2. The admission MDS assessment dated [DATE] revealed Resident #20 had diagnoses of Non-Alzheimer's dementia, bipolar disorder, and anxiety disorder. The MDS documented the resident not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The Care Plan initiated 7/21/25 revealed the resident had a diagnosis of bipolar disorder. The Care Plan indicated the resident had received a PASRR Level II determination. The PASRR dated 7/18/25 revealed the resident had diagnoses of bipolar disorder, major depressive disorder, anxiety disorder and dementia. In an interview on 12/3/25 at 3:40 PM, the MDS Coordinator reported she completed the Resident #6 and Resident #20's MDS assessments. She obtained information to complete the assessments by talking with the resident and she performed the assessment. She entered the resident's diagnoses under section I of the MDS assessment as applicable. She also checked with the Social Services Director if she had a question about how to respond to the PASRR questions on the MDS. She manually filled out the questions under the PASRR section A of the MDS. She coded yes in the section under A1500 if a resident had a diagnosis of a serious mental illness. At the time, the MDS Coordinator checked Resident #6 and Resident #20's admission MDS assessment and confirmed the question under A1500 should have been marked yes. The MDS Coordinator reported she had only worked as the MDS Coordinator since 10/2025 and the MDS assessment had been done prior to her taking on the MDS Coordinator role. In an interview on 12/3/25 at 3:50 PM, the Social Services Director confirmed a diagnosis of bipolar disorder, or major depressive, or anxiety disorder would be classified as serious mental illness, according to the PASRR. 3. The MDS completed 8/28/25 revealed Resident #9 with a Brief Interview for Mental Status score of 7, indicating severe cognitive impairment. Diagnoses include cerebrovascular accident (CVA) and (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-Alzheimer dementia. A wander/elopement alarm was coded as not used. The Care Plan identified Resident #9 at risk for elopement related to impaired safety awareness and dementia. Interventions initiated on 9/21/23 include the use of a wander guard placed on the right ankle. Physician Order Summary obtained on 12/2/25 noted wander guard placement on right ankle and to test its function nightly. This was initiated on 8/25/23. During an observation on 12/3/25 at 12:20 PM, a wander guard alarm was seen on Resident #9's right ankle. During an interview on 12/2/25 at 3:35 PM, Staff A, Certified Nursing Assistant (CNA) acknowledged the use of wander guard alarms in the facility and listed residents who currently wear them. Resident #9 was listed. During an interview on 12/3/25 at 3:15 PM, the MDS Coordinator noted the MDS should reflect the use of a wander guard alarm. Upon further review, the MDS Coordinator acknowledged the wander guard use should be coded on the Resident #9's MDS. During an interview on 12/3/25 at 3:50 pm, the Director of Nursing acknowledged MDS coding discrepancies from the facility's previous MDS Coordinator. Review of the Resident Assessment Interview Manual (RAI) coding instructions for the MDS directed the following for section A1500: PASRR: a. Review the Level I PASRR form to determine whether a Level II PASRR required b. Review the PASRR report provided by the state if [NAME] II screening was required c. Code 1, yes: If PASRR Level II screening determined that the resident has a serious mental illness and/or intellectual disability and continue to A1510, Level II PASRR conditions d. Check all conditions that apply, which include serious mental illness (question A1510) The RAI Manual coding instructions documented the following after determining whether or not an item listed in P0200 (alarms) was used during the 7-day look-back period, code the frequency of use: a. Code 0, not used, if the device was not used during the 7-day look-back period.b. Code 1, used less than daily, if the device was used less than daily.c. Code 2, used daily, if the device was used on a daily basis during the look-back period. Per the RAI the definition of a wander/elopement alarm described as: Wander/elopement alarm includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert the staff when the resident nears or exits a specific area or the building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings.