

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Martin Health Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 410 East 10th 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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48003</p> <p>Based on clinical record review and staff interview the facility failed to notify the state ombudsman as required for emergency transfers for 2 of 3 residents reviewed (Residents #2 and #8). The facility reported a census of 46 residents.</p> <p>Findings include:</p> <p>1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition.</p> <p>The Progress Note written on 12/24/23 at 11:12 PM reflected Resident #2 transferred to the hospital.</p> <p>The Progress Note on 12/25/23 at 7:06 AM listed Resident #2 admitted to the hospital.</p> <p>Review of the December 2023 Ombudsman notification form lacked documentation of Resident #2's discharged to the hospital on 12/24/23.</p> <p>2. Resident #8's MDS assessment dated [DATE] identified a BIMS score of 10, indicating moderately impaired cognition.</p> <p>Resident #8's Census listed statuses of hospital leave on the following dates: 8/30/23, 9/15/23, 12/21/23, 4/12/24, and 7/4/24.</p> <p>The Progress Note on 8/29/23 at 9:05 PM indicated Resident #8 admitted to the hospital.</p> <p>The Progress Note on 9/15/23 at 2:16 PM reflected Resident #8 admitted to the hospital.</p> <p>The Progress Note on 12/21/23 at 2:12 PM identified Resident #8 admitted to the hospital.</p> <p>Review of the August, September and December 2023 Ombudsman notification form lacked documentation of Resident #8 discharged to the hospital on 8/29/23, 9/15/23, and 12/21/23.</p> <p>During an interview on 7/9/24 at 11:43 AM the Administrator reported the facility didn't complete the 2023 Ombudsman reports correctly.</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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/9/24 at 5:11 PM the Administrator reported the facility didn't have a policy related to Ombudsman notification.</p>

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056</p> <p>Based on record review, staff interview, and Resident Assessment Instrument (RAI) Manual the facility failed to complete Significant Change Minimum Data Set (MDS) assessment for 4 of 4 residents (Residents #14, #32, #35, and #37) within 14 days of identifying a significant change occurred. The facility reported a census of 46 residents.</p> <p>Findings include:</p> <p>1. Resident #14's MDS assessment dated [DATE] indicated he didn't receive hospice care while a resident.</p> <p>The Hospice Certification and Plan of Care dated 4/12/24 identified Resident #14 elected to receive Hospice services.</p> <p>The Hospice Medicare Benefit Revocation dated 4/16/24 indicated Resident #14 choose to revoke hospice services.</p> <p>Resident #14's Clinical - MDS record reviewed on 7/11/24 indicated the facility completed an entry MDS assessment on 4/11/24 and a quarterly MDS assessment on 5/22/24. The review lacked documentation of a significant change MDS assessment following Resident #14's election of Hospice benefits or when he revoked his Hospice benefits.</p> <p>Interview on 7/10/24 at 4:00 PM Staff A, Nurse Mentor, stated they didn't have to do a significant change due to Resident #14 went off of hospice within the 14 days and didn't trigger 2 of the significant changes.</p> <p>The RAI Manual dated October 2023 instructed if a nursing home resident elects to receive the hospice benefit, the Centers for Medicare and Medicaid Services (CMS) requires the nursing home complete an MDS Significant Change in Status Assessment (SCSA). In addition, CMS requires a nursing home complete an SCSA when the resident comes off the hospice benefit (revoke). It is a CMS requirement to have an SCSA completed every time someone elects to use their hospice benefit, even if the facility completed a recent MDS and the only change is the election of the hospice benefit. The Significant Change MDS date must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). The assessment reference date (ARD) must be less than or equal to 14 days after the IDT's determined the resident met the criteria for an SCSA (determination date + 14 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination the resident met the criteria for a SCSA. This date may be earlier than or the same as the CAA(s) completion date, but not later than.</p> <p>48003</p> <p>2. The Hospice Admission Consent form dated 6/19/24 identified Resident #32 started receiving Hospice services on 6/19/24.</p> <p>(continued on next page)</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Progress Note dated 6/20/24 at 3:08 PM reflected Resident #32 admitted to hospice on 6/19/24.</p> <p>The Clinical Record Review included an incomplete SCSA dated 7/2/24, greater than 14 days after the determination Resident #32 met the criteria for a SCSA.</p> <p>3. The Medicare Hospice Election Statement dated 5/18/23 listed Resident #35 started Hospice services on 5/18/23.</p> <p>Resident #35's SCSA dated 5/30/23 reflected a completion date of 6/12/23, 11 days past the 14 days after the determination date of 5/18/23.</p> <p>4. The Medicare Hospice Election Statement dated 11/21/23 reflected Resident #37 started Hospice services on 11/21/23.</p> <p>The clinical record review reflected Resident #35's SCSA dated 12/4/23 reflected a late completion date of 12/18/23.</p> <p>During an interview on 7/10/24 at 10:45 AM, Staff B, Nurse Mentor, reported when doing the MDS she followed the ARD when Staff A, Nurse Mentor, set them up. She reported the facility followed the regulations directed in the RAI manual.</p> <p>During an interview on 7/10/24 at 11:30 AM, Staff A, Nurse Mentor, reported when someone went on hospice she set the ARD out a little way to catch everything they need. She reported she didn't know the Hospice MDS SCSA needed completed within 14 days of going on hospice. She reported the facility followed the RAI manual.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49056</p> <p>Based on clinical record review and staff interview, the facility failed to complete a new level I Preadmission Screening and Resident Review (PASRR) for Level I on 12/30/22 for 1 of 1 resident reviewed (Resident #26). The facility reported a census of 46 residents.</p> <p>Findings include:</p> <p>Resident #26's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of anxiety, bipolar disorder, psychotic disorder, and non-Alzheimer's disease.</p> <p>Review Resident #26's PASRR Level 1 Screening Outcome dated 11/30/20 reflected a PASRR Level I Determination, No Level II required.</p> <p>Review of the clinical chart revealed this PASRR came with Resident #26 from another facility, but the current facility failed to submit a new PASRR due to new diagnosis and medication.</p> <p>The Progress Notes dated 6/19/24, and 7/2/24 for Resident #26 revealed follow up psychiatric visits related to bipolar.</p> <p>The Pre Admission Screening and Resident Review (PASRR) policy dated November 2022 revealed: To ensure the identification of nursing facility applicants and residents with serious mental illness and/or intellectual and developmental disability (MI/MR) receive appropriate placement, admission, or the ability to remain in the facility, but only if the facility can appropriately serve and provide the services they need.</p> <ol style="list-style-type: none"> 1. Prior to admission, the referring entity completes the Level I process. 2. The Admission Director or designee reviews the Level I evaluation. 3. If Level I evaluation indicated the need for a Level II, the facility will suspend the admission until the completion of the Level II evaluation or until such time the facility received an exemption. 4. If the resident received a negative Level I evaluation, the facility may admit the resident as long as they can meet the needs of the individual according to the Admission Policy. <p>In an interview on 7/9/24 at 3:29 PM, the Administrator reported the facility missed it. They should have submitted a new PASRR, and they would submit a new one that day.</p>		