STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165622	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Suites at Western Home Communities	5301 Caraway Lane Cedar Falls, IA 50613

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, the Centers for Medicare and Medicaid Services (CMS) Long Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview, the facility failed to complete a Significant Change Status Assessment (SCSA) Minimum Data Set (MDS) Assessment within 14 days of hospice election for 2 of 2 residents reviewed on hospice services (Residents #45 and #4). The facility reported a census of 71 residents. Findings include: 1. A Progress Note dated 5/30/24 at 5:02 PM documented Resident #45 admitted to hospice care services. A Hospice Benefit Election Statement signed by Resident #45's family member documented the start of service date as 5/30/24. The Care Plan Focus revised 6/14/24 reflected Resident #45 started hospice care on 5/30/24. The SCSA MDS assessment dated [DATE] documented Resident #45 with long/short term memory impairment and moderately impaired (required cues) decision making ability. The MDS listed diagnoses of metabolic encephalopathy (a condition where the brain does not function properly due to an imbalance in metabolic processes), hypertension (high blood pressure), thyroid disorder, Alzheimer's Disease, dementia, stroke, malnutrition (inadequate intake of nutrients), anxiety and respiratory failure. The MDS documented Resident #45 had less than six months to live, but lacked documentation Resident #45 received hospice care services. The MDS 3.0 Summary page in Resident #45 Electronic Healthcare Record (EHR) showed the SCSA MDS with a completion date on 6/19/24 (twenty days after the hospice election date). MDS Section Z, Signatures of Persons Completing the MDS showed Staff A, Social Services, Staff B, Quality of Life Services/MDS Coordinator, and Staff C, Quality of Life Services, completed the MDS sections between 6/18/24 and 6/19/24 with Staff B signing section Z0500 verifying the assessment as complete on 6/19/24. (continued on next page)

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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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 12:04 PM the Director of Nursing (DON) reported the facility out sourced the MDS assessments. A Licensed Practical Nurse (LPN) filled out the MDS information, then the MDS Coordinator reviewed the MDS. She didn't know the MDS and trusted the staff who work on the MDS to accurately code the assessment. She reported they had a time when the MDS Coordinator was out sick and their service provider had a different person completing the MDS. They did note problems with MDS accuracy during that time. The DON verified the facility followed the RAI for coding the MDS. During an interview on 2/5/25 at 2:33 PM the Staff B reported she attended the morning meetings, reviewed the progress notes, physician orders to pick up when residents admit to hospice care, and emails from the Household Coordinators. Staff B reviewed section Z of Resident #45's MDS and stated only the Dietician completed the MDS timely. All other disciplines that signed in section Z completed the MDS after day 14. She voiced they completed the SCSA MDS for hospice care late. She reported they followed the RAI manual for completing the MDS. The LTC RAI 3.0 User's Manual Version 1.19.1 October 2024 documented the RAI process had multiple regulatory requirements. The Federal regulations at 42 CFR (Code of Federal Regulations) 483.20 (b)(1)(xviii), (g), and (h) required the assessment accurately reflect the resident's status. The RAI manual specified the SCSA MDS completion date is 14 days from the determination that a significant change in resident status occurred (determination date plus 14 calendar days). 50874 2. Resident #4's SCSA MDS assessment dated [DATE] indicated they received hospice level of care while a resident of the facility and within the last 14 days. Staff B signed the MDS as the RN Assessment Coordinator verifying the completion of the assessment on 1/22/25. A Physician's Order Sheet and Progress Notes dated 1/2/25 for Resident #4 listed a referral for hospice services. A Progress Note dated 1/3/25 at 9:34 AM documented hospice would be meeting with Resident #4 and his/her spouse on 1/3/25 at 1:00 PM. A Progress Note dated 1/3/25 at 2:27 PM reflected Resident #4 admitted to hospice services that day. During an interview on 2/5/25 at 2:15 PM Staff B explained they discussed changes in resident services and conditions at the morning meetings. She added she reviewed the Progress Notes in the electronic health record, checking for changes in the resident payor source, and through direct communication with the facility staff. Staff B reported when a resident elected hospice services the facility followed the RAI Manual by completing a significant change MDS by day 14 from their election of hospice services. Staff B verified the facility completed Resident #4's MDS 6 days late on 1/22/25. A review of the hospice clinical record revealed the following: * Iowa Department of Human Services Election of Medicaid Hospice Benefit dated 1/3/25 signed by Resident #4's spouse. * Resident #4's spouse signed the Hospice Admission Contract on 1/3/25. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Resident #4's Hospice Election Statement signed by Resident #4's spouse with a hospice representative documented hospice services began on 1/3/25. * The Aide Care Plan Report documented the start of care date as 1/3/25. * The Client Medication Report documented the admitted as 1/3/25.

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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 - 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** 42133 Based on observation, clinical record review, document review, the Centers for Medicare and Medicaid Services (CMS) Long Term Care (LTC) Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, and staff interview the facility failed to ensure the Minimum Data Set (MDS) Assessment accurately reflected the care status of 4 out of 5 residents reviewed (Residents #33, #45, #53, and #70). The MDS failed to accurately reflect Resident #33's fall with major injury, Resident #45 received hospice services, Resident #53's use of restraints, and Resident #70 discharged home and not to the hospital. The facility identified a censes of 71 residents. Findings include: 1. The Incident Note dated 9/5/24 at 3:30 PM documented by Staff F, Licensed Practical Nurse (LPN), indicated they heard Resident #33 calling out for help and she entered her apartment. Resident #33 laid on the bathroom floor with her hand placed under her buttocks, wearing gripper socks, and her walker next to her. Resident #33 walked to the bathroom without assistance and went to leave the bathroom to go to her chair. Staff F completed an assessment. Resident #33 described her buttocks as sore but denied pain elsewhere. The Health Status Note dated 9/7/24 at 3:00 PM written by Staff D, Registered Nurse (RN), reflected she heard Resident #33 scream, help, help, come over here to Resident #33's room. Resident #33 laid on the floor beside her bed with three blankets wrapped around her feet. Resident #33 laid tangled up on her right hip and right shoulder. Her head and face laid on top of her wheelchair foot pedal. Resident #33 verbalized her hip and arm both hit the ground at the same time and added her hip hurt with a 10/10 pain level (10 being the worst pain). The facility visited the Provider, who directed them to send Resident #33 to the emergency department (ED). A Hospital X-Ray dated 9/7/24 at 9:02 PM reflected Resident #33 had osteopenia (a condition in which bone density is lower than normal but not low enough to be diagnosed as osteoporosis. It is a precursor to osteoporosis, which is a more severe form of bone loss) and a mildly displaced fracture of the right pubic (lower front part of the hip) bone. The Health Status Note dated 9/7/24 at 10:15 PM documented by Staff E, RN, indicated they received a follow up call from the ED nurse at the hospital. They reported Resident #33 fractured their pubic bone and the ED physician recommended physical and occupational therapy services. Resident #33 would return via ambulance to the facility within the hour. A Major Injury Determination Form signed by the Provider on 9/7/24 documented Resident #33 had an unwitnessed fall on 9/7/24 at 5:00 PM and received a pelvic fracture. The Provider documented after reviewing the circumstances, injury and prognosis, the Provider believed the injury sustained was not a major injury and, to the best of their knowledge, barring any complications, believed the patient (resident) would return to his/her previous functional status. Resident #33's MDS assessment dated [DATE] documented Resident #33 had two or more falls since the last assessment without injuries. The MDS lacked Resident #33's fall with injury which included the pelvic fracture. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/3/25 at 2:22 PM Resident #33 sat in her room chair after lunch with the wheeled walker by the chair. Resident #33 didn't exhibit any signs of pain or discomfort. On 2/4/25 at 12:45 PM observed Resident #33 sitting in the wheelchair at the dining room table eating lunch independently. Resident #33 wore gripper socks and appeared comfortable. During an interview on 2/5/25 at 12:04 PM the Director of Nursing (DON) reported the facility out sourced the MDS assessments. A Licensed Practical Nurse (LPN) filled out the MDS information, then the MDS Coordinator reviewed the MDS. She didn't know the MDS and trusted the staff who work on the MDS to accurately code the assessment. She reported they had a time when the MDS Coordinator was out sick and their service provider had a different person completing the MDS. They did note problems with MDS accuracy during that time. The DON verified the facility followed the RAI for coding the MDS. During an interview on 2/5/25 at 2:41 PM Staff B, Quality of Life Services/MDS Coordinator, reported they have an LPN that coded the MDS and then she checked the MDS over. She reviewed Resident #33's MDS and reported the MDS had two falls with no injuries coded because Resident #33's Physician documented the pelvic fracture as not a major injury. Staff B verbalized she is from out of state and wasn't familiar with Iowa regulations. She voiced being confused and didn't realize the difference between federal regulations and state regulations. She reported they just run across that with another resident and would have to double back and check some other MDS assessments. She voiced when a discipline signed off a section of the MDS they attested the information they entered is correct. She reported they need to follow the RAI for accurate coding of the MDS. She acknowledged the coding of Resident #33 MDS as inaccurate. The LTC RAI 3.0 User's Manual Version 1.19.1 October 2024 documented the RAI process had multiple regulatory requirements. Federal regulations at 42 CFR (Code of Federal Regulations) 483.20 (b)(1)(xviii), (g), and (h) required the assessment accurately reflect the resident's status. The manual directed to document the number of falls with major injury (bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma) since the admission, reentry or prior assessment, whichever is most recent. 2. A Progress Note dated 5/30/24 at 5:02 PM documented Resident #45 admitted to hospice care services. A Hospice Benefit Election Statement signed by Resident #45's family member documented the start of service date as 5/30/24. The Care Plan Focus revised 6/14/24 reflected Resident #45 started hospice care on 5/30/24. The Significant Change in Status Assessment (SCSA) MDS assessment dated [DATE] documented Resident #45 had less than six months to live, but lacked documentation Resident #45 received hospice care services. The MDS assessment dated [DATE] documented Resident #45 received hospice services, but lacked documentation that Resident #45 had less than six months to live. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 2:33 PM the MDS Coordinator reported she attended the morning meetings, reviewed the progress notes, physician orders to pick up on when residents are admitted to hospice care, and emails from the Household Coordinators. The MDS Coordinator verbalized someone miscoded Resident #45's MDS and the quarterly MDS didn't pick up hospice care. Hospice care has to be picked up through a significant change MDS. She acknowledged someone didn't code hospice on the 6/5/24 SCSA MDS. The LTC RAI 3.0 User's Manual Version 1.19.1 October 2024 directed to code residents identified as being in a hospice program for terminally ill persons where an array of services are provided for the palliation, management of terminal illness, and related conditions. The RAI manual specified an SCSA MDS is required to be performed when a terminally ill resident enrolled in a hospice program. 3. Resident #53's MDS assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive loss. Resident #53 required assistance with activities of daily living (ADLs). The MDS included a diagnosis of Alzheimer's disease. The MDS documented Resident #53 used a trunk restraint (any manual method/device that restricted a resident's access to their own body or freedom of movement) less than daily. An Order Review History Report Signed by the Provider on 1/8/25 lacked a physician order for the use of a restraint. On 2/3/25 at 3:06 PM observed Resident #53 lying in bed on her left side, without restraints, resting with her eyes closed. On 2/4/25 at 8:33 AM observed Resident #53 seated in the wheelchair, without restraints, in the main dining room for breakfast. Resident #53 made not attempts to get out of the wheelchair. On 2/4/25 at 1:15 PM witnessed Resident #53 lying in bed on her side, without restraints, resting with her eyes closed. Resident #53's Care Plan lacked documentation they used a restraint. A review completed on 2/4/25 of the February 2025 Task List Report lacked documentation of Resident #53 using a restraint. During an interview on 2/4/25 at 1:18 PM Staff G, Certified Medication Manager (CMA), reported the facility didn't use any type of restraints in general. She stated Resident #53 never used any restraints. Interview on 2/4/25 at 1:20 PM Staff H, Certified Nursing Assistant (CNA), reported to her knowledge Resident #53 never used any restraints. During an interview on 2/4/25 at 1:27 PM Staff J, Registered Nurse (RN), reported Resident #53 never used any physical restraints. During an interview on 2/5/25 at 12:04 PM the DON reported the facility didn't use restraints and Resident #53 never used restraints. She reported someone must have miscoded the MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/25 at 2:33 PM Staff B reported she guessed the restraint got coded as a clerical error from clicking through the MDS Assessment too fast. She couldn't find any reason why Resident #53 had a restraint coded. The MDS Coordinator voiced the MDS didn't accurately reflect Resident #53's status and needed corrected. 4. Resident #70's MDS assessment dated [DATE] identified a BIMS score of 6, indicating a severe cognitive loss. The MDS listed Resident #70 had inattention (easily distractible or having difficulty keeping track of what was said) and disorganized thinking. Resident #70 exhibited delusions (misconceptions or beliefs that are firmly held, contrary to reality) and wandering for 1 3 days per week. Resident #70 required supervision/touch assistance to partial/moderate assistance with activities of daily living (ADL's). The MDS listed diagnoses of non Alzheimer's dementia, atrial fibrillation (abnormal heart rhythm), coronary heart disease (impaired vessels in the heart), heart failure (inadequate pumping of the blood resulting in a backup of fluid into the body), end stage renal disease (impaired kidney function), and respiratory failure (impaired breathing). The MDS documented Resident #70 received Physical Therapy (PT) services and planned to discharge back to the community. The Health Status Note dated 11/11/24 at 1:34 PM documented Resident #70 discharged to home with family. The facility provided Resident #70's wife with discharge instructions, education, a copy of the medication list, and physician appointments. The Social Services Note dated 11/17/24 at 4:59 PM indicated Resident #70 discharged with arranged 24/7 caregiving and hospice care to independent living with his Care Plan goals met. A 11/11/24 Recapitulation of Stay/Discharge Summary documented Resident #70 discharged to home/assisted living. A review of the progress notes from 9/28/24 to 11/11/24 lacked documentation of any hospitalization s. On 2/6/25 at 9:10 AM the Administrator verified Resident #70 didn't have any hospitalization s from 9/28/24 to 11/11/24. A November 2024 Notice of Transfer Form to the Long-Term Care Ombudsman documented Resident #70 discharged to a private home/apartment with home health services on 11/11/24. Resident #70's MDS Nursing Home discharge date d 11/11/24 MDS identified they discharged to a short term general hospital (acute care hospital). The MDS inaccurately documented Resident #70's discharge location. During an interview on 2/6/25 at 9:12 AM the Administrator reviewed the MDS Discharge record and reported it must be a clerical error. They set up a meeting with the MDS vendor to address the MDS issues from the survey. She voiced Resident #70 discharged back to independent living on hospice care services as he planned on admission.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42133 Based on observation, clinical record review, and staff interview the facility failed to follow a physician order to place washcloths in the hands of 1 of 1 resident reviewed for range of motion (ROM) (Resident #45). The facility identified a census of 71 residents. Findings include: Resident #45's Minimum Data Set (MDS) assessment dated [DATE] listed Resident #45 as rarely/never understood with long- and short-term memory impairment. Resident #45 had an upper extremity (shoulder, elbow, wrist, hand) functional impairment on both sides. The MDS reflected Resident #45 depended upon staff for activities of daily living (ADLs). The MDS included diagnoses of metabolic encephalopathy (a change in how your brain works due to an underlying condition. It can cause confusion, memory loss and loss of consciousness. You may make a full recovery if you receive a diagnosis and treatment quickly, but permanent brain damage is possible), stroke, Alzheimer's dementia and non Alzheimer's dementia. The MDS documented Resident #45 didn't receive scheduled or as needed (PRN) pain medication during the assessment period. Resident #45 received hospice care services. A Hospice Comprehensive Assessment and Care Plan Update Report listed a Hospice Physician Order dated 10/9/24 for the facility staff to wash hands with soap and water daily. Then pat (hands) dry and placed rolled washcloths, slowly release fingers to wrap around the cloth. The Care Plan Focus revised 12/10/24 indicate Resident #45 had an ADL self-care performance deficit related to limited physical mobility. The Intervention dated 10/20/23 directed to place the pink palm protector on the left hand during the day and remove for meals. Apply the blue palm protector to the right hand during the day and remove for meals. The Care Plan lacked revision related to the physician order to apply rolled washcloths from 10/9/24. A Hospice Comprehensive Assessment and Care Plan Update report with a start date of 12/4/24, reflected the hospice staff reviewed with the facility during their skilled nursing visit about Resident #45 having contractures to both hands and washcloths in place to bilateral hands. Hospice Residential Communication Forms from September 2024 to January 2025 for the hospice nurse visits and home health aide visits lacked documentation of any pain to the hands from the use of washcloths. An Order Summary Report Signed by the Provider on 1/6/25 documented a physician order dated 10/10/24 to wash hands with soap and water, dry daily, roll washcloths and place in hands daily, keep intact through the day, gently separate the finger two times a day. Review of the February 2025 Electronic Treatment Administration Record (ETAR) reflected a physician order to wash hands with soap and water, dry daily, roll washcloths and place in hands daily, keep intact through the day, gently separate the fingers signed off as completed morning and hour of sleep by the nursing staff from 2/3/25 2/5/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/25 at 8:25 AM observed Resident #45 lying in bed supine (on her back) with her arms across her chest, fists clenched, with no rolled washcloths in the palms of her hands. A review of the February 2025 Task Record on 2/4/25 at 8:27 AM revealed the following: a. Resident to wear blue palm protectors both hands during the day between meals; b. Wash hands with soap and water, dry daily, roll washcloths and place in hands daily. The Task Record lacked an update to place washcloths in the palm per the 10/9/24 physician order. On 2/4/25 at 1:01 PM Resident #45 sat in her room in a Broda wheelchair. Observed her with her arms across her chest without washcloths in her clenched fists. On 2/4/25 at 1:07 PM witnessed Staff G, Certified Medication Aide (CMA), and Staff I, Registered Nurse (RN), perform a full mechanical body lift from the Broda wheelchair to the oversized bed. Staff G and Staff I performed peri care, repositioned Resident #45, covered her, performed their own hand hygiene, and left the room. Neither staff member placed washcloths in Resident #45's palms. On 2/5/25 at 7:28 AM saw Resident #45 sitting in the Broda wheelchair at the dining room table for breakfast. Resident #45 sat with her arms crossed across her chest with her fists tightly clenched without washcloths in the palms of her hands. During an interview on 2/4/25 at 1:16 PM Staff G, reported Resident #45 is pretty flexible in her palms and can open her palms. She didn't have pain when she opened her hands. On 2/4/25 at 1:20 PM Staff H, Certified Nursing Assistant (CNA), reported Resident #45 had blue hand splints that she is supposed to wear between meals, but when she tried to put them in, she cried and moaned with pain. On 2/4/25 at 1:24 PM Staff I reported hospice took the blue palm splints away and recommended to use the washcloths because Resident #45 had pain in her hands. The washcloths just help so they can get her hands open better. During an interview on 2/5/25 at 12:27 PM the Director of Nursing (DON) reported if the nurses signed it off on the ETAR then they should complete the physician order. If the resident doesn't need the treatment, then the nurses should notify the physician or contact hospice to get the orders changed. She expected if the nurses sign the physician order, they completed the physician order. The Physician/Extender Policy, reviewed December 2024 directed the following: a. Orders not followed (medications held, refusals, etc.) require notification to the Primary Care Provider (PCP) within approximately 24 hours and need documented in the electronic healthcare record (EHR). b. Orders questioned by the nurse or pharmacist or difficult to read need clarified with the PCP or on call provider and documented in the EHR. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Policy lacked direction to the nursing staff to not sign physician orders if not completed.