| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165418 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/04/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **Simpson Memorial Home** | **1000 NORTH MILLER STREET , WEST LIBERTY, Iowa, 52776** |

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| F0000 ✓ KG | INITIAL COMMENTS<br><br>Correction date: **12/17/2025**<br><br>The following deficiencies resulted from the facility's annual recertification survey conducted on December 1, 2025 to December 4, 2025.<br><br>See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. | F0000 | Please accept this statement outlined below as our credible allegation of compliance for the two deficiencies noted for F0580 and F0641. | 12/17/2025 |
| F0580<br>SS = D | Notify of Changes (Injury/Decline/Room, etc.)<br><br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br><br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br><br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br><br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. | F0580 | On 12/03/2025, the Director of Nursing notified Resident Number 17's physician of the significant weight loss at 180 days noted in the Registered Dietitian's Progress Note of 1/14/2025 along with the interventions that were implemented. Acknowledgment from the provider was received back by the Director of Nursing on 12/04/2025. The Notification and Response is submitted with this plan of correction.<br><br>On 12/16/2025, after discussions with the Administrator, Director of Nursing, and Registered Dietitian, the community's Weight Assessment and Intervention Policy was revised to clarify and make explicit the workflow process for notifying the physician of significant weight loss in residents. On 12/17/2025, the revised policy was, discussed, reviewed and signed off on by the Medical Director, Registered Dietitian, Director of Nursing, MDS Coordinator, and Administrator. The revised and signed Weight Assessment and Intervention Policy is submitted with this plan of correction.<br><br>The Administrator will confirm (at least) monthly with the Registered Dietitian a list of any residents that month that had a significant weight loss and then perform (at least) a monthly audit of physician notifications of the significant weight loss and responses from the provider. A proposed audit sheet is submitted with this plan of correction.<br><br>These audits will be reviewed at Quarterly QAPI Meetings. The frequency and/or need for continuing audits will be discussed and determined by the QAPI Committee. | 12/03/2025<br><br>12/17/2025<br><br>Ongoing<br><br>Ongoing |

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 reverse for further 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 |
|---|---|---|
| | Administrator | 12/22/2025 |

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| F0580 SS = D | Continued from page 1<br><br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident<br><br>representative(s).<br><br>§483.10(g)(15)<br><br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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.<br><br>Findings include:<br><br>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.<br><br>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.<br><br>The Weight Change Progress Notes, completed by the RD | F0580 | | |

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| F0580 SS = D | Continued from page 2<br>revealed, in part:<br><br>1.On 1/7/25 at 3:50 PM...a significant weight loss was identified at 30 days...<br><br>2.On 7/5/25 at 10:19 AM...a significant weight loss was identified at 90 days...<br><br>3.On 10/6/25 at 7:14 PM... a significant weight loss was identified at 180 days...<br><br>4.On 11/4/25 at 9:20 AM...a significant weight loss was identified at 180 days...<br><br>Review of the electronic health record (EHR) lacked documentation of physician notification of the above significant weight changes.<br><br>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.<br><br>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.<br><br>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.<br><br>The policy Weight Assessment and Intervention, revised March 2022 noted the following:<br><br>1.Resident weights are monitored for undesirable or unintended weight loss or gain<br><br>2.The physician and the multidisciplinary team identify conditions and medication that may be causing anorexia, weight loss or increasing risk of weight loss | F0580 | | |
| F0641 SS = D | Accuracy of Assessments<br><br>CFR(s): 483.20(g)(h)(i)(j)<br><br>§483.20(g) Accuracy of Assessments.<br><br>The assessment must accurately reflect the resident's | F0641 | On 12/10/2025 the MDS Coordinator changed the MDS Assessment to correctly identify that Resident Number 9 utilized a wander guard alarm. The corrected MDS Assessment entry is submitted with this plan of correction. | 12/10/2025 |

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| F0641 SS = D | Continued from page 3<br>status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br><br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br><br>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>§483.20(j) Penalty for Falsification.<br><br>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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.<br><br>Findings include:<br><br>1. The annual Minimum Data Set (MDS) assessment dated 6/20/25 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 | F0641 | On 12/17/2025 the MDS Coordinator changed the MDS Assessment to correctly identify that Resident Number 6 was a PASSR Level II and to correctly identify that Resident Number 20 was a PASSR Level II. The corrected MDS Assessment entries are submitted with this plan of correction.<br><br>Although not done specifically in response to the identified issues; since the date of the incorrect MDS entries, the community hired a new MDS Coordinator with several years more experience and training than the MDS Coordinator that was in place at the time of the incorrect entries.<br><br>The current MDS Coordinator did correctly identify to the Surveyors in her interview that she understood what the proper coding should have been for the three identified deficiencies and that she would have coded them correctly had she made the entries.<br><br>The current MDS Coordinator is an LPN (the prior MDS Coordinator was an RN) so the Director of Nursing, an RN, will be reviewing and signing off on all MDS submissions and will be checking to make sure that Residents with PASSR Level II and Residents utilizing a wander guard alarm are correctly documented.<br><br>The Director of Nursing will perform (at least) a monthly audit of all residents that are PASSR Level II or that utilize a wander guard alarm to ensure that they have been documented correctly in the MDS Assessment. A proposed audit sheet is submitted with this plan of correction.<br><br>These audits will be reviewed at Quarterly QAPI Meetings. The frequency and/or need for continuing audits will be discussed and determined by the QAPI Committee. | 12/17/2025<br><br>12/03/2025<br><br>Ongoing<br><br>Ongoing<br><br>Ongoing |

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| F0641 SS = D | Continued from page 4<br>disability receive the most suitable care) process to have a serious mental illness and/or intellectual disability or a related condition.<br><br>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.<br><br>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.<br><br>2. The admission MDS assessment dated 6/26/25 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.<br><br>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.<br><br>The PASRR dated 7/18/25 revealed the resident had diagnoses of bipolar disorder, major depressive disorder, anxiety disorder and dementia.<br><br>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.<br><br>In an interview on 12/3/25 at 3:50 PM, the Social | F0641 | | |

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| F0641 SS = D | Continued from page 5<br>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.<br><br>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 non-Alzheimer dementia. A wander/elopement alarm was coded as not used.<br><br>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.<br><br>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.<br><br>During an observation on 12/3/25 at 12:20 PM, a wander guard alarm was seen on Resident #9's right ankle.<br><br>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.<br><br>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.<br><br>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.<br><br>Review of the Resident Assessment Interview Manual (RAI) coding instructions for the MDS directed the following for section A1500: PASRR:<br><br>a. Review the Level I PASRR form to determine whether a Level II PASRR required<br><br>b. Review the PASRR report provided by the state if Levell II screening was required<br><br>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 | F0641 | | |

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| F0641 SS = D | Continued from page 6<br><br>d. Check all conditions that apply, which include serious mental illness (question A1510)<br><br>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:<br><br>a. Code 0, not used, if the device was not used during the 7-day look-back period.<br><br>b. Code 1, used less than daily, if the device was used less than daily.<br><br>c. Code 2, used daily, if the device was used on a daily basis during the look-back period.<br><br>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. | F0641 | | |