STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165214	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lantern Park Specialty Care	2200 Oakdale Road Coralville, IA 52241

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19126 Based on clinical record review, staff and resident interviews and observations the facility failed to update residents care plans to reflect their current level of functioning for 1 of 4 residents reviewed (Resident #1). The facility reported a census of 85. Findings include: According to the quarterly Minimum Data Set (MDS) dated [DATE] the resident had diagnoses which included metabolic encephalopathy, legal blindness, lack of coordination and muscle weakness. The resident required substantial assistance of staff for transfers from the bed to chair, ambulation and had total dependence on staff for toileting needs. The resident utilized a wheelchair to move about the facility. Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated he gave reliable information. Review of the Care Plan dated 1/4/2024, last revised on 3/25/24, indicated the resident will continue to participate in his activities of daily living as his condition allows. The care plan informed the staff the resident uses a wheelchair, requires 1 person to assist him with toileting, and transfers using a front wheeled walker with 2 staff assist. The care plan revealed the resident is at risk of falls. Observation on 9/16/24 at 11:23 am Staff C- C.N.A. entered the resident's room to assist him to the bathroom. The C.N.A. brought in the sit to stand mechanical lift (EZ stand) to assist the resident to the bathroom. Staff C transferred the resident to the bathroom, allowed him to void and assisted him to his wheelchair. Review of the Nursing/Therapy Communication sheet dated 1/17/2024 directed the staff to transfer Resident #1 with a front wheeled walker with 2 assist. During an interview with Staff I-Physical Therapy Assistant on 9/16/24 at 2:30 pm revealed in January 2024 the resident required assist of 2 staff with walker for pivots and did not use a sit to stand lift at that time. Staff I indicated nursing will request therapy to see the resident and complete an evaluation if the staff notice a change in their transfer abilities. The therapy department did not receive a request from nursing staff for another evaluation and didn't know the resident utilized an EZ Stand for all transfers. During an interview with Staff C-C.N.A. on 9/16/24 at 1:45 pm revealed she has been using the EZ Stand to transfer the resident from bed/chair to another surface for the past 4 months. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Staff H-LPN on 9/16/24 at 1:45 pm, Staff H indicated she has been coming to the facility since January 2024 and the staff have always utilized an EZ Stand to transfer the resident. During an interview with Staff D-C.N.A. on 9/16/24 at 1:45 pm, Staff D stated she has been employed at the facility since May 2024 and they have always used an EZ Stand to transfer the resident. During an interview with Staff J-Director of Nurses on 9/17/24 at 10:45 am revealed physical therapy will determine if the staff can use an EZ Stand when transferring a resident. The therapy department will send recommendations to the nursing department, the staff then are expected to check the Kardex to see how the residents are transferred. During an interview with Staff K-LPN and Staff L RN-CO-MDS Coordinators on 9/17/24 at 10:55 am, both nurses stated a resident will be re-evaluated if they sustain a fall or if staff request an evaluation. Both nurses reviewed the care plan and acknowledged the care plan directs the staff to use a front wheeled walker with 2 staff for transfers and didn't know the staff were using an EZ Stand with the resident for transfers. They revealed the process is the therapy department will assess and send recommendations to the nursing department. The recommendation is then placed in the resident's Kardex and this is how the staff would know how to transfer their residents.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 20331 Based on clinical record review, observation, staff interview and facility policy, the facility failed to transfer a resident who required a mechanical lift in a safe manner for one of three residents reviewed. (Resident #2). The facility reported a census of 85 residents. Findings include: The MDS (Minimum Data Set) dated 8/15/2024 indicated Resident #2 had no cognitive impairment, had diagnoses including Cerebrovascular Accident (stroke), hypertension and hemiplegia (paralysis of one side of the body). The non-ambulatory resident required total assistance of staff to use the toilet and transfer from one surface to another. The Care Plan revealed the resident had hemiplegia following a cerebral infarct affecting the left, non-dominant side dated 7/31/2024. The resident did not ambulate and required the assistance of one staff to transfer and use the toilet with the use of a sit to stand (E-Z stand) mechanical lift. Communication from therapy to nursing dated 7/30/2024 recommended staff use the E-Z Stand for all transfers, wheel chair for mobility and assistance of one staff for activities of daily living. Observation on 9/16/2024 at 9:42 A.M. revealed Staff C, C.N.A. responded to the resident's request to use the restroom. Staff C brought the E-Z Stand lift to the resident's room, positioned it in front of the resident's wheel chair, attached the torso harness and assisted the resident with placing her feet on the foot platform. Staff C failed to buckle the shin strap and indicated it failed to have a buckle in order to secure it. Staff C assisted the resident to hold onto the lift with both hands, and raised her up, transferred her to the bathroom and lowered her onto the toilet. Staff C unbuckled the harness, handed the resident the call light and left the room. At 9:54 A.M. the resident pulled the bathroom call light and Staff D, C.N.A. responded and assisted the resident. Staff D reapplied the harness, raised the resident from the toilet and pulled the lift away from the toilet. Staff D provided cares and transferred the resident with the E-Z Stand lift from the bathroom to the wheel chair positioned in the resident's room, approximately ten feet away. During the transfer the resident's left leg remained straight and tilted back, away from the shin pad. Staff E, PTA (Physical Therapy Aide) entered the room and reported the resident often leaned back out of fear. Staff E indicated he did not like the resident's leg position during the transfer. On 9/16/2024 at 1:20 P.M., Staff D revealed she had not been trained to buckle the leg harness. Staff D knew to always buckle the back harness. On 9/16/2024 at 1:30 P.M., Staff C revealed she knew to buckle the leg strap, however the strap had no buckle. Staff C recently completed the Relias (online) education regarding the use of the E-Z Stand lift and knew to buckle the torso and leg harnesses. On 9/16/2024 at approximately 10:00 A.M. with Staff F, Corporate Nurse revealed the facility had three E-Z Stand lifts. One of three lifts had a broken shin strap. Staff F instructed Staff G, Maintenance to repair the lift. Staff G indicated the facility had the needed buckle to make the repair. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/2024 at 9:20 A.M., Staff J, DON (Director of Nursing) revealed staff need to apply the leg strap at all times when they transfer a resident using the E-Z Stand lift. The E-Z Way Smart Stand mechanical lift manual revised 7/30/2018 included: Position shin pad and foot plate: Use of Shin Pad Strap: If a caregiver deems it necessary to keep a patient's shins or feet on the foot plate, secure the shin strap around the patient's legs. 2) Position the unit in front of the patient. 3) Have patient place feet (help patient if needed) on foot plate and position their shins into the shin pad. The shin pad should be positioned below the knees.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 20331 Based on clinical record review, observation, staff interviews, and facility policy review the facility failed to provide appropriate supervision with ambulation that resulted in injury for one of four residents reviewed. (Resident #4). The facility reported a census of 85. Findings include: The MDS (Minimum Data Set) dated 8/15/2024 revealed Resident #4 had no cognitive impairment, transferred to the toilet with partial/moderate supervision and had bladder and bowel incontinence. The MDS indicated the resident had diagnoses including periprosthetic fracture around internal prosthesis left hip (a break in the bone around the joint replacement), pneumonia and anemia. On 2/29/2024 the resident's Care Plan identified the resident had pain related to his periprosthetic fracture of the left hip joint, and had a fall risk. It instructed staff to monitor for unsteady gait, encourage to use call light for assistance, provide a safe environment and wear proper footwear. The Care Plan directed staff to provide assistance for activities of daily living and indicated the resident transferred with moderate independence and a front wheeled walker on 2/28/2024. A revision on 9/9/2024 directed staff to transfer the resident with assistance of one staff and a wheeled walker and use a wheel chair to follow for long distances. The Care Plan with a revision on 9/17/2024 revealed the resident changed to non-ambulatory status. The Therapy to Nursing Communication note dated 9/6/2024 recommended staff provide the assistance of one staff and a front wheeled walker and wheel chair for mobility in the halls, and the assistance of one staff with front wheeled walker in his room. The Progress Notes included the following: 9/11/2024 - Hospice to evaluate and admit. 9/13/2024 - admit to hospice, care plan updated. 9/14/2024 at 4:07 P.M. - resident fell in the bathroom using a walker and no gait belt. At 4:31 P.M. - EMS (Emergency Medical Services) on way to transport. At 10:45 P.M. - resident returned to facility via EMS services, resident has a fracture right hip, greater trochanter and non-operable. An Emergency Department After Visit Summary dated 9/14/2024 revealed the resident had an x-ray that showed a fracture of the greater trochanter that did not require surgery, and should heal on its own. The summary indicated the resident could bear weight as tolerated, but would not be able to bear weight over the next several weeks. The hospital x-ray report included: History: unwitnessed fall, complained of right hip pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Two views of the right hip. FINDINGS: Acute fracture of the greater trochanter of the right femur. IMPRESSION: 1. Acute mildly displaced periprosthetic fracture of the greater trochanter of the right femur. Observation on 9/17/2024 at 8:15 A.M. revealed the resident in bed with oxygen on via nasal cannula, head of bed elevated and pillows underneath his bilateral lower extremities. Observation revealed the resident's recliner sat approximately 6 feet from the bathroom doorway. Staff H, LPN (Licensed Practical Nurse) indicated the resident remained in bed due to the fall and his non-weight bearing status. The resident appeared alert and verbal, and when interviewed, he had no recall of the injury. He reported he had pain and must have fallen on his butt. Staff H offered the resident morphine, however, he refused. On 9/17/2024 at 9:20 A.M., Staff J, DON (Director of Nursing) revealed the facility terminated Staff A due to a final warning related to similar incidents. Staff A, C.N.A. assisted Resident #4 to the restroom, stood him from the recliner with a walker and failed to apply a gait belt. Staff A removed the resident's oxygen when he reached the bathroom doorway, turned away from him to place the tubing on the recliner, and the resident fell after she left go of him. Staff B, C.N.A. in training, entered the room, observed the resident take a couple of steps on his own and fell . When staff attempted to assist him in standing, he complained of pain and he transferred to the emergency department. An x-ray revealed he fractured his right greater trochanter and it was non-operable. Staff J provided education to all staff, instructed them to use a gait belt at all times and look to the Kardex (care card) if they needed to look up information on each resident. Staff receive a gait belt when they are hired and are expected to have it on them at all times. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/16/24 at 2:15 PM., Staff A, C.N.A. stated she worked the evening shift on 9/14/24, assigned to Resident #4. Staff A responded to the resident's call light and his request to use the restroom. Staff A observed the resident in the recliner with oxygen on per nasal cannula, with tubing attached to the oxygen concentrator. Staff A placed the resident's walker in front of him and assisted him to standing position by grabbing the back of his slacks and assisted in lifting him up. Staff A admitted she failed to place a gait belt on the resident, and ambulated with the resident to the bathroom door. Staff A stated she thought the oxygen tubing was too short for him to make it to the toilet so she removed the oxygen from the resident and she turned away from him. She took one step out of the bathroom so she could place the oxygen tubing on his recliner. She admitted she released her grip from the resident's jeans allowing him to stand in the bathroom alone. She reported she did not witness the resident fall as he was standing in the bathroom alone. Staff B did witness the resident's fall as entered the resident's room. Staff A heard a crash and found the resident sitting on the floor just inside his bathroom door way. The resident continued to indicate he had to use the toilet. Staff B left the room to get the nurse. The nurse entered the room and asked what happened. Staff A reported the resident fell and she failed to use a gait belt. Staff placed a gait belt on him, attempted to assist him up, but he complained of hip pain. The resident stated he thought he broke something. The nurse left the room to call 911. Staff A worked the remainder of her shift and left at 10:30 PM. When asked why she did not use a gait belt, Staff A stated she did not see one in his room and she had left her gait belt in her back pack in her locker. Since she had no gait belt, she held onto the resident's pants to assist him in going to the restroom. Staff A knew to check the resident's Kardex or ask another staff if she needed to know what assistance a resident required to safely transfer or ambulate. Staff A learned during her C.N.A. training to always use a gait belt when a resident required assistance with transfers. Staff A failed to recall if the facility instructed her to use a gait belt during her orientation. Staff A stated the facility terminated her employment due to this incident and a prior similar incident where she failed to use a gait belt when transferring a resident. Staff A admitted she should have used a gait belt on 9/14/24 when she assisted Resident #4 to the bathroom as he required staff assistance with transfers. On 9/17/2024 at 9:50 A.M., Staff B, C.N.A., in orientation, revealed she arrived to work on 9/14/24 at 3:30 P. M. She first observed Staff A, C.N.A. in Resident #4's room. Staff B walked into the resident's room and witnessed Resident #4 fall in his bathroom. She indicated Staff A stood several feet outside the resident's bathroom as the resident stood alone with his walker approximately 2 feet inside the bathroom. Resident #4 had no gait belt on him at that time. Staff B observed the resident take two small, rapid steps, lose his balance, twisted his body and fell . The resident landed on his bottom with his back against the wall, and his walker landed towards the bathroom sink. The resident initially did not yell out, but subsequently stated he broke his leg and hip. Staff B summoned the nurse and they called 911, and the resident transferred to the hospital. Staff A and Staff B discussed the fall with the nurse, and they were instructed to always use a gait belt, and if needed, let the oxygen tubing fall on the floor as it can be replaced. Staff B stated she had no way to quickly reference how a resident transferred. She would have to leave the resident's room and check the computer or ask another staff. Staff B stated she did not know what assistance Resident #4 required to transfer. Staff A's Corrective Action Form dated 9/17/2024 revealed the facility terminated her due to assisting a resident to the bathroom without a gait belt, turned her back to the resident and the resident fell . The facility Nursing Assistant Orientation Checklist included: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	#19. Resident Transfer - Assist ambulation - gait belt. The facility Safe Lifting and Movement of Residents revised July, 2027 included: Policy Statement: In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Policy Interpretation and Implementation 1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. 2. Manual lifting of residents shall be eliminated when feasible. 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include: Resident's preferences for assistance; Resident's mobility (degree of dependency); Resident's size; Weight-bearing ability; Cognitive status; Whether the resident is usually cooperative with staff; and the resident's goals for rehabilitation, including restoring or maintaining functional abilities. 4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. 5. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary. 6. Only staff with documented training on the safe use and care of the machines and equipment used in this facility will be allowed to lift or move residents. 7. Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques.