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	10/17/2024

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

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48888

Based on interview, clinical review review, and facility policy review, the facility failed to thoroughly investigate an allegation of physical abuse for 1 of 3 residents reviewed for dignity. The facility reported a census of 84 residents.

Findings include:

The Minimum Data Set (MDS), dated [DATE], reviewed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition.

On 10/11/24, the facility collected a statement from Resident #2 in which the resident alleged that during the overnight hours of 10/03/24, she had been hit in the head with a back hand, which caused glasses to be knocked off face and fall across the floor near the bathroom. Resident #2 informed that the glasses did not break and upon waking, no one was there. Resident #2 claimed she did not see who allegedly hit her but heard a person call her an exploitive name. Resident #2 reported she had been unable to report the incident until 10/11/24 as she had gotten sick.

On 10/11/24, the facility asked 7 current residents, with intact cognition, the following questions:

Do you know who to report abuse to?

Have you ever witnessed a staff member hit someone?

Have you ever been mistreated?

No additional resident concerns identified from the above questions asked.

On 10/11/24, the facility obtained a statement from Staff D, Licensed Practical Nurse (LPN), which provided information on Resident #2's recent respiratory illness and hospitalization . Staff D's statement lacked information related to alleged abuse.

On 10/11/24, the facility obtained a statement from Staff E, Certified Nursing Assistant (CNA), which provided information on Resident #2's recent respiratory illness and hospitalization . Staff E's statement lacked information related to alleged abuse.

(continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided nursing staff schedules for the dates of 10/03/24 and 10/04/24. According to the facility schedules, neither Staff D or Staff E worked with Resident #2 during the time frame in which the alleged incident occurred. On 10/16/24 at 11:30 AM, Staff C, LPN, confirmed they had worked the morning of 10/04/24 with Resident #2. Staff C denied any reports received that Resident #2 had been hit or had glasses knocked off her face. Staff C stated that Resident #2 had previously made paranoid comments at times but denied Resident #2 ever making false allegations. Staff C denied being asked by facility to write any recent statements regarding Resident #2. On 10/16/24 at 12:30 PM, Staff F, LPN, confirmed they had worked overnight shift on 10/03/24 with Resident #2. Staff F denied any reports received that Resident #2 had been hit or had glasses knocked off her face. Staff F stated she believed Resident #2 had a normal night on 10/03/24. Staff F denied being asked by facility to write any recent statements regarding Resident #2. On 10/17/24 at 1:30 PM, Interim Facility Administrator informed that they had been made aware of Resident #2's allegation of being hit on 10/11/24 from review of Hospital notes. Administrator stated in response to the allegation he notified regional clinical staff, police, and the Department of Inspections, Appeals, and Licensing (DIAL). Administrator informed that facility had documented that Resident #2 had yellow drainage from the right eye related to an eye infection, but no signs of injury noted. Administrator revealed he went to the Hospital on 10/11/24 to interview Resident #2 and delegated staff interviews to be conducted by the Interim Director of Nursing (DON). Administrator unsure if staff who worked the night of allegation or the following day had been interviewed. On 10/17/24 at 2:13 PM, Regional Director of Clinical Services, stated that the Interim Administrator would obtain additional staff interview at this time from staff who worked with Resident #2 during the alleged incident and was unaware this had not been completed previously. The facility provided an untitled document, dated 10/11/24, that summarized the facility's investigation of Resident #2's allegation of abuse that occurred 10/03/24. Document revealed that the facility reviewed the witness statements, and Resident #2's MDS, Care Plan, face sheet, and medication list as part of the investigation. Document concluded that from staff and resident interviews conducted, there were no concerns noted. The facility policy titled, Abuse and Neglect- Clinical Protocol, revised March 2018, revealed the expectation that the facility will investigate alleged abuse to clarify what happened and identify possible causes.

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NAME OF PROVIDER OR SUPPLIER: Lantern Park Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 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** 48888 Based on resident and staff interview, clinical record review, and facility policy review, the facility failed to obtain physician orders when utilizing supplemental oxygen or transcribe verbal order for supplemental oxygen for 1 of 3 residents (Resident #2) reviewed for assessment/intervention. The facility additionally failed to administer medications as ordered when multiple morning and afternoon medication doses were omitted on 10/08/24 for 1 of 10 residents (Resident #6) reviewed for medication administration. The facility reported a census of 84 residents. Findings include: 1. Resident #2 example: The Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Resident #2 diagnoses included Chronic Obstructive Pulmonary Disease (COPD) and asthma. No shortness of breath or oxygen therapy indicated on MDS assessment. The Care Plan, dated 8/27/24, lacked respiratory focus area for diagnosis of COPD or asthma. The Care Plan lacked intervention related to use of oxygen. Review of Nursing Progress Note, dated 10/07/24 at 04:08 AM, revealed that Resident #2 had an oxygen saturation of 71% on room air (normal results being greater than 90%), nurse applied 3 liters (L) of oxygen in response, and oxygen saturation improved. -On 10/09/24 at 1:36 AM, a Nursing Note informed that Resident #2's oxygen saturation had been 76%, nurse applied 4L of supplemental oxygen in response, and notified the Provider on resident's condition with a verbal order received for oxygen 4L via nasal cannula for shortness of breath. Resident #2 refusing hospitalization . -On 10/09/24 at 4:54 PM, Resident #2's lips had been purple and oxygen saturation found to be between 49-51% on room air, supplemental oxygen applied at 4L with improved saturation. -On 10/10/24 at 11:33 AM, Resident #2 complained of shortness of breath and generalized pain all over, oxygen saturation found to be 88% while wearing 4L of oxygen, Resident #2 transferred to the hospital. The Medication and Treatment Administration Record (MAR/TAR), dated October 2024, lacked any orders for supplemental oxygen administration. On 10/16/24 at 11:30 AM, Staff C, Licensed Practical Nurse (LPN), informed that Resident #2 had not always required routine supplemental oxygen and revealed that an order would be required for use of oxygen to know how many liters of oxygen to use and how often. On 10/16/24 at 12:07 PM, Interim Director of Nursing (DON) confirmed that Resident #2 lacked oxygen order in the resident's MAR/TAR. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Lantern Park Specialty Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 1:00 PM, the Regional Director of Clinical Services, informed that on 10/07/24 oxygen was applied to Resident #2 per nursing judgment, and on 10/09/24 a verbal order received from the Provider to apply oxygen at 4L via nasal cannula. The Regional Director of Clinical Services revealed that other nurses would not know that Resident #2 required oxygen or how much to use without an order in place. The facility policy titled, Oxygen Administration, revised October 2010, revealed the expectation of staff to verify that there is a physician's order for oxygen administration and to review the physician's order for oxygen administration. 45338 2. Review of the MDS assessment for Resident #6 dated 7/18/24 revealed the resident scored 15 out of 15 on a BIMS exam, which indicated intact cognition. Review of the resident's October 2024 MAR revealed the following medications were marked with a code of 9, which indicated other/see progress notes, for morning medications on 10/8/24: Cholecalciferol 1000mg (milligram) two tablets, Glycopyrrolate 1mg, Midodrine Hcl 5mg (medication to treat low blood pressure), Rivastigmine 3mg two capsules, Carpidopa-Levodopa 25-250mg (for Parkinson's Disease), and two doses of Refresh Celluvisc Opthalmic Gel 1% (scheduled for AM and mid per MAR). Review of Progress Notes for Resident #6 revealed the following: a. 10/8/24 at 10:51 AM, authored by Staff A, Registered Nurse (RN): Missed administration d/t (due to) not enough help. b. 10/8/24 at 2:02 PM: Missed administration d/t not enough help. c. 10/9/2024 at 1:23 PM [Name Redacted] ARNP (Advanced Registered Nurse Practitioner) of medication error on 10/8/24, no new orders received. Review of the Daily Staffing Sheet dated 10/8/24 revealed two nurses and one Certified Medication Aide (CMA) were scheduled to work first shift. Staff A was one of the two nurses scheduled to work. On 10/17/24 at 8:16 AM, the facility's Regional Director of Clinical Services (RDCS) explained both she and the Regional Director of Operations (RDO) were at the facility on 10/8/24. When queried if Staff A had come to the RDCS with any concerns, the RDCS acknowledged Staff A had not done so, had not asked for help, or let them know she needed anything. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 8:48 AM during an interview with the Regional Director of Operations (RDO), the RDO explained the following about what had occurred on 10/8/24: Staff A had asked the RDO if she could connect prior to Staff A leaving. Per the RDO, as Staff A was walking out (of facility), the RDO said it looked like they did not connect. Per the RDO, Staff A explained she did not have a lot of time and needed to get out of (facility), said she (Staff A) didn't get everything done today, later further clarified per interview as supplemental documentation and a couple/some meds (medications). The RDO explained Staff A asked if she could come back the next day. The RDO further explained she (RDO) connected with the team and it had not just been a couple of meds, was a lot of AM meds. The RDO explained Staff A had been at the facility until around 3:30 PM, and had been scheduled for 6:00 AM to 2:00 PM on the date of the incident. Review of the Charge Nurse-RN Job Description revised 4/18 revealed, in part, the following per the Essential Functions Section: Assume responsibility for unit/shift staff compliance with rules, regulations, standards of practice and facility policy and procedure; assure that residents receive needed nursing care and services on that shift, according to plans of care and physicians' instructions.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 45338 Based on clinical record review, staff interview, and facility policy review the facility failed to ensure residents were free from significant medication errors for six of ten residents reviewed for medication administration (Resident #3, Resident #4, Resident #12, Resident #13, Resident #14, and Resident #15). The facility reported a census of 84 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment for Resident #3 dated 8/1/24 revealed the resident scored 5 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. Review of the resident's October 2024 Medication Administration Record (MAR) revealed multiple morning medications marked with a code of 9, which indicated other/see progress note. The resident's morning medications not given included Metoprolol Succinate ER Tablet Extended Release 24 hour 25mg (milligrams), with instructions to give 0.5 tablet by mouth once a day for hypertension. Review of Progress Notes for Resident #3 revealed the following: a. 10/8/24 at 10:58 AM authored by Staff A, Registered Nurse (RN): Missed administration d/t (due to) not enough help. b. 10/9/2024 at 1:25 PM: Notified [Name Redacted] ARNP (Advanced Registered Nurse Practitioner) of medication error on 10/8/24, no new orders received. 2. Review of the clinical record revealed the MDS Assessment for Resident #15 remained in progress. Resident #15's Care Plan dated 10/4/24 revealed, I have altered cardiovascular status related to Paroxysmal Atrial Fibrillation, Cardiomyopathy, Unspecified, Essential (Primary) Hypertension, Acute on Chronic Diastolic (Congestive) Heart Failure). Review of the resident's October 2024 MAR revealed multiple morning medications marked with a code of 9. The resident's morning medications not given included Digoxin Oral Tablet 125 MG. Review of Progress Notes for Resident #15 revealed the following: a. 10/8/24 at 10:53 AM authored by Staff A: Missed administration d/t not enough help. Review of the Daily Staffing Sheet dated 10/8/24 revealed two nurses and one Certified Medication Aide (CMA) were scheduled to work first shift. Staff A was one of the two nurses scheduled to work. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/17/24 at 8:48 AM during an interview with the Regional Director of Operations (RDO), the RDO explained the following about what occurred on 10/8/24: Staff A had asked the RDO if she could connect prior to Staff A leaving. Per the RDO, as Staff A was walking out (of facility), the RDO said it looked like they did not connect. Per the RDO, Staff A explained she did not have a lot of time and needed to get out of (facility), said she (Staff A) didn't get everything done today, later further clarified per interview as supplemental documentation and a couple/some meds (medications). The RDO explained Staff A asked if she could come back the next day. The RDO explained she (RDO) connected with the team and it had not just been a couple of meds, was a lot of AM meds. The RDO explained Staff A had been at the facility until around 3:30 PM, and had been scheduled for 6:00 AM to 2:00 PM on the date of the incident. Review of the Facility Policy titled Administering Medications, revised 4/19, revealed the following: Medications are administered in accordance with prescriber orders, including any required time frame .the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 48888 3. Resident #4 example: Review of the MDS assessment for Resident #4 dated, 9/13/24, revealed the resident scored 11 out of 16 on a BIMS exam, which indicated moderately impaired cognition. Resident #4 had diagnosis of Diabetes Mellitus. The Care Plan, initiated 1/15/22, revealed Resident #4 required insulin related to diagnosis of Diabetes Mellitus with an intervention that instructed staff to administer insulin as ordered by physician. Review of the resident's October 2024 MAR indicated that the morning dose of Insulin Glargine 18 units had been given by Staff A on 10/08/24. Review of Progress Notes for Resident #4 revealed the following: On 10/08/24 at 9:55 AM, a note written by executive department informed that Resident #4 missed medication insulin glargine 18 units morning dose and weekly weight. On 10/9/2024 at 1:25 PM: Notified Provider of medication error on 10/8/24, no new orders received. 4. Resident #12 example: Review of the MDS for Resident #12, dated 7/12/24, revealed the resident scored 14 out of 15 on a BIMS exam, which indicated intact cognition. Diagnoses included: atrial fibrillation, Heart Failure, and Coronary Artery Disease (CAD). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's October 2024 MAR revealed multiple morning medications marked with a code of 9, which indicated other/see progress note. The morning medications not given included Metoprolol Tartrate 50mg (milligrams), with instructions to give 1 tablet by mouth twice a day for hypertension, Furosemide (Lasix) 20mg, with instructions to give 2 tablets daily for blood pressure, and Eliquis 5mg, with instructions to give 1 tablet twice a day for blood clots. Review of Progress Notes for Resident #3 revealed the following: a. 10/8/24 at 10:58 AM, authored by Staff A, Registered Nurse (RN): Missed administration due to not enough help. b. 10/9/2024 at 1:25 PM: Notified Provider of medication error on 10/8/24, no new orders received. 5. Resident #13 example: Review of the MDS assessment for Resident #13, dated 9/23/24, revealed the resident scored 15 out of 15 on a BIMS exam, which indicated intact cognition. Diagnoses included Diabetes Mellitus, Coronary Artery Disease (CAD), and hypertension Review of the resident's October 2024 MAR revealed multiple morning medications marked with a code of 9, which indicated other/see progress note. The morning medications not given included Carvedilol 25mg, with instructions to give 1 tablet by mouth twice a day for hypertension and Furosemide (Lasix) 20mg, with instruction to give 1 tablet by mouth twice per day for hypertension. The MAR additionally revealed omission of morning and noon doses Insulin Aspart 5 units, with instructions to inject 5 units subcutaneously at meal times. Review of Progress Notes for Resident #14 revealed the following: a. 10/8/24 at 10:58 AM, authored by Staff A, Registered Nurse (RN): Missed administration due to not enough help. b. 10/9/2024 at 1:25 PM: Notified Provider of medication error on 10/8/24, no new orders received. 6. Resident #14 example: Review of the MDS assessment for Resident #14, dated 9/12/24, revealed the resident scored 12 out of 15 on a BIMS exam, which indicated moderately impaired cognition. Review of the resident's October 2024 MAR revealed multiple morning medications marked with a code of 9, which indicated other/see progress note. The morning medications not given included Furosemide (Lasix) 20mg, with instructions to give 1 tablet by mouth once a day for Congestive Heart Failure (CHF), Metoprolol Succinate ER Tablet Extended Release 24 hour 25mg (milligrams), with instructions to give 0.5 tablet by mouth once a day for hypertension, and Levetiracetam (Keppra) 500mg, with instructions to give 1 tablet by mouth twice per day for seizures. Review of Progress Notes for Resident #14 revealed the following: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. 10/8/24 at 10:58 AM, authored by Staff A, Registered Nurse (RN): Missed administration due to not enough help. b. 10/9/2024 at 1:25 PM: Notified Provider of medication error on 10/8/24, no new orders received.