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	07/31/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, facility policy review, and staff interviews, the facility failed to educate a resident and/or a resident representative and obtain an informed consent prior to two changes in psychotropic medications for 1 of 3 residents (Resident #60) reviewed. The facility reported a census of 86 residents.Findings include:Review of the Minimum Data Set (MDS) assessment, dated 7/2/25 for Resident #60 revealed diagnoses list which included post-traumatic stress disorder (PTSD), depression, and adjustment disorder with mixed anxiety and depressed mood. A Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicated a severe cognitive impairment. Review of the Care Plan revealed Focus areas to address: a. I feel down or depressed at times. Date initiated: 12/9/24.b. I feel lonely or isolated at times. Date initiated: 3/11/25.c. I have a history of physical or emotional trauma. Date initiated: 3/15/25.d. I use antipsychotic medications related to depression. Date initiated: 4/16/25. A Focus area, dated initiated 3/7/25, addressed I use Duloxetine an antidepressant medication. Interventions included, in part Educate me, my family, and caregivers about risks, benefits and the side effects and/or toxic symptoms of antidepressant medication. Date Initiated 9/28/24. Review of a document titled Medical Record-Doctor's Orders, dated 6/20/25 revealed Week 1: decrease duloxetine to 30 mg (milligrams) daily and start sertraline 50 mg daily. Week 2: Stop duloxetine and increase sertraline to 100 mg daily (continue until follow-up). Continue prazosin 1 mg QHS (every bedtime). Continue quetiapine 100 mg QHS. Continue trazodone 25 mg BID (twice daily). Follow up in 6 weeks.Review of the electronic health record (EHR) revealed a Order-Administration Note entered at 9/24/25 at 9:11 AM revealed N.O. (new order) from VA (Veteran Affairs) - Week 1: Decrease Duloxetine to 30 mg daily and start Sertraline 50 mg daily; Week 2: Stop Duloxetine and increase Sertraline to 100 g daily (continue until follow-up). Continue Prazosin 1 mg q HS; Continue Quetiapine 100 mgq HS. Continue Trazodone 25 mg BID; Follow up in 6 weeks. Entered into [redacted brand name of EHR system]Review of a Communication-with Family note entered on 6/24/25 at 0:33 AM revealed Attempted to notify [name of Resident #60 wife redacted] of new orders. Left message for her to call facility for notification. Review of the EHR revealed a lack of follow up communication with the Resident #60's family representative regarding the change in psychotropic medications ordered on 6/20/25 and started on 6/24/25. Review of a SPN - Focused Evaluation noted entered on 6/25/25 at 10:04 AM revealed, in part:.Monitoring d/t (due to) decrease dose of Duloxetine and N.O. Sertraline. Initial dose of each this morning. No s/s (signs/symptoms) adverse rxn (reaction) @ this time. Will continue to monitor. During an interview on 7/31/25 at 9:49 AM, the Administrator stated when a medication change is made there would be a signed informed consent document to indicate the resident and/or family representative was informed and educations on the change. Review of the facility provided Informed Consent for Psychotropic Medication for Resident #60 psychotropic medications revealed an unsigned consent with an effective date for 6/24/25 for Antidepressant Zoloft (sertraline) 25-200 mg per day, once daily dosing. On 7/31/25 at 11:35 AM by email communication, the Administrator stated the facility does not have a policy related to Mental Health Monitoring. The Administrator provided a policy titled Change in Condition Policy, revised March 2018. The policy did not address the need for informed consent to be completed prior to a change in psychotropic medications.

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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 Based on clinical record review, Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 dated October 2023 (RAI) review and staff interview the facility failed to complete a Minimum Data Set for a significant change after a hospice admission for 1 of 4 residents (Resident #2) reviewed for hospice. The facility reported a census of 86 residents. Findings include:Review of Physician Orders for Resident #2 revealed Order Details entered on 6/2/25 with the Description: Receiving Hospice services from [provider name redacted] for Alzheimer's dementia effective 4/14/25. Review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 dated October 2023 (RAI) page 2-17 directed providers, in part .the MDS completion date is no later than the 14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days). Page 2-25 of the RAI directed, in part .an SCSA (Significant Change in Status Assessment) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home.During an interview on 7/31/25, the MDS Coordinator confirmed Resident #2 started to receive hospice services on 4/14/25. She stated a significant change MDS should have been completed.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, Resident Assessment Instrument (RAI) manual review, and staff interviews the facility failed to complete quarterly Minimum Data Set assessments in a timely manner for 3 of 3 residents (Resident #49, Resident #51, Resident #84) in the sample. The facility reported a census of 86 residents.Findings include: 1. Review of the electronic health record (EHR) revealed Resident #49 admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) assessment documented a completion date of 2/26/25. Review of the MDS history list indicated a MDS Quarterly assessment completed on 7/18/25. A space of 142 days after the admission assessment. 2. Review of the EHR revealed Resident #51 admitted to the facility on [DATE]. The admission MDS assessment documented a completion date of 1/3/24. Review of the MDS history list indicated MDS Quarterly Assessments completed on 3/7/25, and 7/18/25. A space of 133 days between the assessments. 3. Review of the EHR revealed a Quarterly MDS assessment for Resident #84 completed on 9/30/24, with the next assessment completed on 1/3/25. A space of 95 days between the assessments. During an interview on 7/31/25 at 8:33 AM with the facility's new MDS Coordinator and the Administrator, the Administrator stated the corporate support team had been doing the MDS assessments on and off while a new Coordinator was hired. The MDS Coordinator indicated the nursing portion would be completed by her, social services and activities and dietary would do their own sections, and she would submit the final assessment. She stated the quarterly assessments should be completed within 92 days. The Administrator stated the prior Coordinator should have completed the assessments. The MDS Coordinator stated her training for the last few weeks had been correcting the errors they found. When asked if the facility had filled out the Self Identification form at the beginning of the survey to indicate MDS corrections were something they were working on, the Administrator said no. She stated they just opened them and fixed them. They MDS Coordinator indicated she would use the corporate team and the RAI manual for support going forward.Review of the RAI User's Manual dated October 2024, Version 1.19.1, page 2-18, revealed a direction for an assessment to be completed every 3 months. The Manual directed the assessment reference date could be no later than the last assessment plus 92 calendar days.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview and staff interview the facility failed to provide at least 2 baths per week for 2 of 3 residents (Residents #13 and Resident #61) reviewed. The facility reported a census of 86 residents. Findings include:1. Review of the Minimum Data Set (MDS), dated [DATE], revealed Resident #13 with Brief Interview for Mental Status (BIMS) score 14 out of 15 which indicated intact cognition. The MDS assessed Resident #13 required substantial/maximal assistance for showering. Review of the Care Plan, dated 9/27/23 revealed a Focus area to address Activities of Daily Living (ADL's). Interventions included, in part: Bathing: I require 1 assist. Date Initiated: 9/27/23. During an interview on 7/28/25 at 11:30 AM, Resident #13 stated she does not get showers very often. Review of Resident #13's Documentation Survey Report V2 for April, May, June and July 2025 revealed the resident was scheduled for a shower twice a week on Tuesday and Friday. Resident #13 documented showers occurred in April 2025 on April 4, April 23, and April 24; in May 2025 on May 4, May 9, May 20, May 23, May 30, and May 31; in June 2025 on June 2, June 10, June 13, and June 27; and in July 2025 on July 1, July 8, July 11, July 15, and July 16. 2. Review of the MDS, dated [DATE], revealed Resident # 61 with a BIMS score 15 out of 15 which indicated intact cognition. The MDS assessed Resident #61 required substantial/maximal assistance for showering. Review of the Care Plan, dated 10/17/23 revealed a Focus area to address Activities of Daily Living (ADL's). Interventions included, in part: Bathing: I require x1 assist. Date Initiated: 10/17/23. During an interview on 7/28/25 at 1:19 PM, Resident #61 explained staff are slow to give showers. He stated he hadn't had a shower for over a week. The resident appeared to have greasy hair, and a slight body odor. Review of Resident #61's Documentation Survey Report V2 for April, May, June and July 2025 revealed the resident was scheduled for a shower twice a week on Tuesday and Friday. Resident #61 documented showers occurred in April 2025 on April 1, April 8, April 23, April 24, and April 25; in May 2025 on May 2, May 6, May 9, and May 20; in June 2025 on June 3, June 10, June 13, June 21, June 25, and June 27; and in July 2025 on July 1, July 2, July 11, July 15, July 18, and July 29. During an interview on 7/31/25 at 11:17 AM, the Administrator explained everyone should be getting a shower twice a week.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, clinical record review, staff and resident interviews, and policy review the facility failed to ensure respiratory care devices are on and operational for 2 of 3 residents reviewed (Residents #1 and #18) and failed to maintain oxygen tubing in a clean and sanitary manner for 1 of 3 residents reviewed (Resident #1) for respiratory care. The facility reported a census of 86.Findings include: 1. The Minimum Data Set (MDS) for Resident #18 documented diagnoses of pulmonary hypertension due to left heart disease, heart failure, and dependence on supplemental oxygen. The Care Plan (CP) for Resident #18 documented altered respiratory status related to congestive heart failure, the resident experienced frequent shortness of breath, and staff should monitor oxygen at 2-4 liters and ensure sats were at comfort levels (88%-95%). During an interview with Resident #18 on 7/28/25 at 11:01 AM she indicated she had troubles breathing on and off. She pointed at the concentrator in her room and said it wasn't on, then stared at the machine to see if she could tell what number it was on. She thought she was hooked up to the concentrator. The resident stated she was was short of breath the other night, ended up in the emergency room, and once in awhile things like this happened. She clarified she meant the concentrator wasn't on or the tank wasn't working. During the interview the surveyor observed the oxygen tubing in her nose did not have a date tag on it and was attached to the portable tank behind her on her wheelchair. The tank was not producing a flow according to the resident. At 11:09 AM on 7/28/25 the resident put her call light on for help. 4 minutes later Staff E, Certified Nurses Aide (CNA) came in to help her. When asked if the oxygen should have been running through the tank or her tubing hooked up to the concentrator, he said yeah probably. He unhooked the tubing from the portable tank and indicated it was not running. He plugged it into the concentrator and turned it on. On 7/31/25 at 2:03 PM Resident #18 was in her room with family. They reported that her breathing seemed good today but they had come in a couple of times to find the portable was out of oxygen and she was not hooked up to the concentrator. At this time the resident stated she felt short of breath and wanted the nurse. The nurse left the resident's room at 2:11 PM on 7/31/25 at told the Administrator the resident 'desated' a couple of days ago and it was causing her to feel anxious that it would happen again. 2. The MDS for Resident #1 documented diagnoses of pneumonia, acute and chronic respiratory failure, and chronic obstructive pulmonary disease (COPD). The CP for Resident #1 revealed the resident experienced altered respiratory status/difficulty breathing. Staff provided oxygen therapy for sleep apnea, assistance with BiPAP/CPAP equipment, and ensured oxygen was set at 2 liters per nasal cannula. Staff were directed to ensure oxygen equipment was running. During an observation on 07/28/2025 at 2:19 PM the resident was in the common area with his nasal cannula hooked up to a portable oxygen tank talking with the hospice nurse. Staff determined the tank was not running and brought out the concentrator from his room. During an observation on 7/30/25 at 9:45 AM Resident #1 was out of his room. The oxygen tubing, dated 7/28/25, was attached to the concentrator in his room and partially wrapped in a circle around the top of the machine. A portion of the tubing approximately two feet long was hanging off of the side of the machine with a section about 4 inches long touching the side of a garbage can. The garbage contained an open brief and a soiled wipe hanging over the side. The tubing touched the side of the brief and the plastic of the garbage can liner. On 7/31/25 after breakfast the resident was observed using oxygen tubing dated 7/28/25. On 7/31/25 at 8:51 AM Staff B, Certified Medication Aide (CMA) stated tanks were monitored every shift, and that management encouraged concentrators instead of tanks because the tanks go fast. They didn't want residents to desaturate. She stated all staff were responsible for monitoring tanks and thought residents on 2 liters of oxygen should be checked at least every 45 minutes. During an interview with Staff C, Nurse, on 7/31/25 at 9:11 AM she stated the nurses did pretty much everything related to oxygen care. They dated the tubing, made sure it was the appropriate length, made sure the water was bubbling, ensured tanks were full, and made sure there was oxygen coming through the tubing. She didn't think the Certified Nursing Aides (CNA) did much with oxygen. She stated it was her job to switch residents from portable tanks to concentrators if needed. She wasn't sure about the tubing being on the floor next to the garbage can. She had not been made aware resident tanks were running out. On 7/31/25 at 9:27 AM the Director of Nursing stated any nursing personnel can turn the tanks on and off and bring concentrators to common areas, they just can't change the flow. She did not expect them to be off of the portable tanks in their rooms but did expect them to be running on the right setting and working no matter which one they used. Ideally they would switch to the concentrator in their rooms A policy titled Oxygen Administration revised October 2010 directed staff to

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, clinical record review, interviews, and policy review the facility failed to provide trauma informed care for 1 of 3 residents reviewed (Resident #60). Resident #60 experienced suicidal ideations that were not addressed in their care plan, staff did not adequately monitor mental health behavior for patterns and medication changes, and staff were not able to articulate resident behavior triggers. The facility reported a census of 86 residents. Findings include: The Minimum Data Set (MDS) for Resident #60 dated 7/2/25 documented diagnoses of post traumatic stress disorder (PTSD), depression, and adjustment disorder with mixed anxiety and depressed mood. His Brief Interview for Mental Status (BIMS) assessment resulted in a score of 6/15, which indicated severe cognitive impairment. The Care Plan (CP) for Resident #60, with an admission date of 3/7/25, documented focus areas as follows:12/9/24 the resident felt down or depressed at times3/7/25 the resident used duloxetine as an antidepressant3/11/25 the resident felt lonely and isolated at times3/15/25 the resident had a history of physical or emotional trauma4/16/25 the resident used an antipsychotic related to depressionA CP goal was to not have a trauma triggered event. It did not identify the type of trauma, trauma triggering events, or signs and symptoms that indicated the resident was experiencing a trauma response. Another goal indicated the resident would decrease episodes of verbally aggressive behavior towards his wife and family by 50%. It did not address verbally aggressive behavior towards others in the facility or triggering events to watch for.The CP did not include the resident's history of suicidal ideations, safety measures or a crisis plan, or suicidal behavior monitoring. It did not include the resident's history of nightmares, medication for nightmares, or monitoring protocol.A point of care document used daily by the Certified Nursing Assistants (CNAs) printed on 7/30/25 did not include behavior monitoring, triggers, or interventions.The resident's Supplemental Documentation printed by the facility on 7/31/25 at 10:42 AM for July indicated the resident should be monitored for behaviors related to the use of antidepressant medication sertraline, trazodone, and duloxetine every shift as follows: 0- no behaviors; 1- lack of motivation; 2- excessive crying; 3- suicidal thoughts; 4- loss of appetite; 5- social withdrawal; 6- self isolation; 7- other see progress notes.Intervention codes included: 0- None; 1- encourage to voice concerns; 2- 1:1 with social services; 3- call family/friend; 4- weighted blanket; 5- music; 6- take a walk; 7- diversional activity; 8- other.A checkmark on the MAR meant administered. From 7/7/25 through 7/30/25 one day had a 6 and one day was blank. The remaining days contained a checkmark only.An additional section directed staff to document behaviors related to PTSD, and if there were no behaviors staff should enter a progress note. Of the 90 entries for 7/1/25 through 7/30/25 2 were blank, one contained the number 6, and the rest contained a checkmark. Corresponding progress notes indicated 1 shift of behavior monitoring on 7/6/25 and 7/8/25. No behavior documentation occurred in the progress notes on 7/5/25, 7/9/25, 7/10/25, 7/13/25, or 7/20/25 through 7/22/25.The task tab of the EHR indicated staff should monitor behavior symptoms PRN (as needed). There were no entries for the past 30 days. The facility did not provide the most recent psychology appointment summary for review.During an observation on 7/28/25 at 11:07 AM the resident was wheeling himself down the hall in his wheelchair past another resident's room. He yelled that he was going to protect his country and nothing could stop him, swung his arms in the air and at the resident's door, talked to himself, and grimaced. He groaned, started mumbling under his breath, and then yelled shut up and no dammit. The other resident asked the surveyor to shut her door and indicated this was not new behavior. During an observation on 7/28/25 at 12:41 PM Resident #60 left the dining room table independently in his chair and spoke to staff at the nurses station. He was then observed in the hallway shouting that his wife never came to see him and was cheating on him. An interview with Staff B, Certified Medication Aide (CMA) on 7/31/25 at 8:51 AM revealed she hadn't done much hands on non-pharmacological interventions with the resident. She didn't know what triggered some of his behaviors and he needed to be reassured a lot. She stated the nurses got the paperwork from his psychology appointments and they (CNA/CMA) were not allowed to see that. She thought behavior monitoring and interventions might be on the MAR.During an interview with Staff C, Nurse on 7/31/25 at 9:11 AM she stated she wasn't really sure what the resident's triggers were. She knew he got upset when he saw or talked to his wife sometimes, though it was just when she came in and when she left. Staff C stated all staff could watch for behavior changes. She reported a lot of recent medication changes. Staff C tried to put behavior information in the progress notes and thought that was where it should be but said there might be a behavior tab. She did not know what happened at his last appointment with the psychologist On 7/31/25 at 1:21 PM Staff D, Social Services Director, stated the

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview and staff interview the facility failed to answer call lights in 15 minutes or less for 3 of 3 observations for call light response. The facility reported a census of 86 residents.Findings include:During an interview on 7/28/25 at 3:20 PM, Resident # 18 explained it takes a long time for staff to answer call lights, over 15 minutes. During an interview on 7/28/25 at 4:06 PM, Resident # 3 explained it takes 35-40 minutes for staff to answer call lights. During an observation on 7/28/25, the call light was observed on for room [ROOM NUMBER] at 3:30 PM. Staff did not enter the resident's room until 4:05 PM. The light was observed on for 35 minutes. During an observation on 7/28/25, the call light was observed on for room [ROOM NUMBER] at 3:40 PM. Staff did not enter the resident's room until 4:10 PM. The light was observed on for 30 minutes. During an observation on 7/31/25, the call light was observed on for room [ROOM NUMBER] at 8:47 AM. Staff did not enter the resident's room until 9:04 AM. The light was observed on for 17 minutes. During an interview on 7/31/25 at 11:17 AM, the Administrator explained her expectation would be for call lights to be answered in less than 15 minutes.