STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165231	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Park Nursing & Rehab Center of Carroll	500 East Valley Drive Carroll, IA 51401

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, staff interviews and personnel file review, the facility failed to provide dignity to 2 of 4 residents (Resident #1, Resident #2) reviewed. The facility failed to provide dignity to the residents as demonstrated by residents stating they felt their care was rough due to the speed in which their care was provided. The facility reported a census of 33 residents. Findings Include: 1. The Minimum Data Set (MDS) for Resident #1, dated 6/1/25, identified a Brief Interview for Mental Status (BIMS) score of 15/15 indicating normal cognition. The resident had diagnoses of atrial fibrillation, heart failure, peripheral vascular disease, diabetes mellitus, anxiety, depression, and other specified disorders of bone, ankle, and foot. The document identified the resident as having a Stage 2 pressure ulcer on buttocks and no moisture associated skin damage (MASD). The resident required substantial/maximal assistance with toilet hygiene, lower body dressing, and partial/moderate assistance with personal hygiene and transfers. The document revealed the resident as being continent of bladder. Resident #1's Care Plan with revisions dated 5/29/25 to 7/1/25 revealed a focus area of impaired skin integrity initiated on 5/29/25 with revisions on 6/10/25, 6/12/25, and 6/17/25 reflecting open areas noted on 6/8/25 to the left and right abdominal folds, left abdominal/groin area, and right groin/peri-area and healed on 6/17/25. Interventions for staff included: administration of treatments as ordered, application of protective ointment to prevent skin breakdown, encourage the resident to avoid scratching, keep hands and body parts from excessive moisture, and keep fingernails short. An additional focus area of self care deficit initiated 6/4/25 and revised on 6/20/25 provided interventions for staff including: assist of 1 staff for bed mobility, personal hygiene hygiene as needed, toileting with peri-care with every incontinent episode and as necessary, and transfers dated 6/4/25. An additional intervention was added 6/8/25 for providing skin care to wash gently and pat dry all skin folds to prevent skin breakdown. The Electronic Medical Record (EMR) Progress Notes entry on 6/8/25 at 7:00 AM revealed Resident #1 had asked Staff A, Certified Nurse Assistant (CNA), for assistance with care as she (the resident) felt wet in her folds. The document revealed the resident asked the staff to stop during care as she was going too fast and it was painful. The document included a statement from the resident indicating Staff A was in too much of a hurry, wanted to get things right now, and if she would slow down it would look much more kind. The entry added that Staff A closed the blinds against the resident's wishes and told the resident she must go to bed at 9:00 PM because that was when everyone goes to bed even though the resident wanted to stay up until 10 or 10:30 PM. 2. The MDS for Resident #2, dated 6/20/25, revealed a BIMS score of 15/15. The resident had diagnoses of atrial fibrillation, diabetes mellitus, Non-Alzheimer's Dementia, and spinal stenosis. The document indicated the resident was dependent for toilet and personal hygiene, and transfers. The resident required substantial/maximal assistance for dressing and movements from lying to from sitting. The document indicated the resident was usually continent of bladder. Resident #2's Care Plan dated 7/28/25 revealed a focus area related to self care deficits with revision on 6/23/25. The interventions for staff included assistance of 1 staff for bed mobility, un/dressing, toileting with peri-care with every incontinent episode, and hygiene tasks. On 8/4/25 at 12:50 PM Resident #2 stated Staff A seemed to rush and hurry, moving her quickly and completing care quickly. The resident stated she did not feel the care was abusive but rather rushing and may occasionally be rough when wiping or applying lotion. Review of (4) Annual Employee Reviews for Staff A found the staff met or exceeded in job expectations, but each year a comment was entered related to the need to slow down with one review specifically indicating the need to slow down when completing care and explain to the resident what was being done.On 8/4/25 at 12:07 PM Staff C, Licensed Practical Nurse (LPN), stated Staff A rushes when completing work. The staff elaborated stating Staff A knows things that need to be done and hurries to get them completed. On 8/4/25 at 12:18 PM Staff D, CNA, stated Staff A was always on the move and rushing to get things done. The staff stated she had heard residents state Staff A would rush through cares, but did not provide specific names. On 8/4/25 at 1:18 PM, Staff B, CNA, stated she had heard various staff swearing while at work. The staff stated the swearing could occur in front of residents and/or residents' families. The staff stated Resident #1 told her Staff A was always in a hurry and felt that her care at times was rough. Staff B stated she did not believe it was intentionally rough, rather the mannerism in which it was completed due to the speed. On 8/4/25 at 1:47 PM Staff E, CNA, stated when working with Staff A, she observed her (Staff A) be in a hurry to complete a task/care to get to the next resident. On 8/4/25 at 2:20 PM Staff F, CNA, stated Staff A would sometimes be in a rush when completing care, which could be construed as rough care when it was not rough but hurried care. On