STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165593	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scottish Rite Park Inc	2909 Woodland Avenue Des Moines, IA 50312

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 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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34817

Based on record review, staff interview, and policy review, the facility failed to implement and follow safety interventions on the Care Plan to use a gait belt for 1 of 4 residents reviewed (Resident #1). Resident #1 sustained a fall and fractured her left ankle. The facility reported a census of 30 residents.

Findings include:

The Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had diagnoses of arthritis, osteoporosis, intervertebral disc disorder (a breakdown or degeneration of the discs that cushion the spine), and physical debility. The MDS recorded the resident had a Brief Interview for Mental Status of 9, indicated moderately impaired cognition. The MDS documented the resident required partial to moderate assistance for transfers and ambulation.

The MDS assessment dated [DATE] revealed Resident #1 had an unplanned discharge to the hospital.

A Significant change MDS assessment dated [DATE] revealed the resident readmitted to the facility from the hospital on 9/16/24. The MDS documented the resident had diagnoses of a displaced left bimalleolar (medial and lateral sides of the ankle) fracture, osteoporosis, and COVID-19. The MDS recorded the resident had a fall with a major injury during the look-back period, and dependent on staff for toileting and transfers.

The Care Plan initiated on 6/11/24 revealed the resident required assistance with Activities of Daily Living revised on 9/16/24 revealed non-skid strips placed in front of the recliner (added to the Care Plan on 9/6/24), and the resident non-ambulatory and required a mechanical lift and assistance of two staff for transfers.

An Incident Report dated 9/8/24 at 5:35 PM revealed Resident #1 sat on the floor on her buttocks with her back against the recliner and walker in front of her. The resident reported her knee gave out when she walked backwards to the chair. She reported pain in her left ankle. The resident had tested positive for COVID-19. She also had a history of weakness in her right knee and wore a knee brace. The incident report documented Staff A, Certified Nursing Assistant (CNA) statement about the incident as follows; On 9/8/24, as me and the resident were walking to the recliner, the resident started turning to sit down. As she went to sit, her knee gave out and I guided her to the ground.

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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: 165593	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Scottish Rite Park Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2909 Woodland Avenue Des Moines, IA 50312	

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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 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's investigation file included a summary of the incident summary (typed and written by the Chief Nursing Officer (CNO)). The incident summary revealed Resident #1 began showing signs and symptoms of COVID-19 and tested positive on 9/8/24 AM. On 9/8/24 at 5:35 PM, the CNA walked the resident from the bathroom back to the recliner chair. Per CNA statement, resident started to turn and her knee gave out as she began to sit. The CNA guided her to the floor. Resident complained of left ankle pain. The Physician's Assistant (PA) saw the resident on 9/9/24. X-ray of left ankle indicated a fracture. Resident was sent to the hospital for evaluation and treatment. In an interview on 1/6/25 at 2:45 PM, Staff B, Licensed Practical Nurse (LPN) reported Resident #1 required assistance of one for ambulation and transfers. She was alert and oriented, but got confused occasionally. She got up and transferred herself only once in a while. She had a fall on the weekend. Staff A, CNA was in the room getting the resident ready and said the resident had fallen. Staff B reported she went into the room to assess her. Staff A told her the resident was taking a step back toward the recliner, and her ankle rolled. Staff A told her she helped lower the resident to the floor. Staff B confirmed when she walked in and saw the resident on the floor in front of her recliner, she did not have a gait belt on. Staff B thought the resident's ankle fractured when the resident rolled her ankle. Staff B reported the facility required staff use a gait belt at all times unless the resident was independent or was care planned otherwise. After the incident, the facility gave all of the staff a gait belt. The resident rooms already had a gait belt prior to the incident. Staff B reported that Staff A got written up for not using a gait belt. In an interview 1/6/25 at 3:30 PM, Staff C, Registered Nurse, reported Resident #1 required the assistance of one, and used a walker and a gait belt for transfers. The resident had a risk for falls. Staff C reported it was standard for staff to use a gait belt unless it was on the resident's Care Plan to do something else. In an interview 1/6/25 at 3:45 PM, Staff A, CNA, reported when she came to work, she got a copy of the resident list for her assigned area to reference as needed and to know how a resident transferred. Staff A reported Resident #1 had a knee brace because her knee would be wonky and weak sometimes. She would ask Resident #1 if she was comfortable using the walker or if she wanted to use the wheelchair. The resident usually wanted to walk with her walker. Staff A reported she would follow behind Resident #1 with a wheelchair if the resident was weaker. Staff A acknowledged she worked on the day Resident #1 had a fall. The resident had COVID. The resident did ok with walking when she assisted the resident to the bathroom earlier that day. Later in the day, Staff A held the back of the resident's pants as the resident ambulated from the bathroom. As Resident #1 turned, her left knee gave out, and she stumbled up against the walker and the recliner. Staff A reported she lowered the resident to the ground. Staff A confirmed she did not have a gait belt on the resident. She only used a gait belt for those residents who really needed assistance. That was what she was told to do. She didn't use a gait belt much for Resident #1 because she didn't require as much assistance. After the incident, a manager pulled her aside and had her sign a paper on what to do in the future. She was told she needed to use a gait belt when someone had COVID or was sicker. She had to sign a form that said she needed to be more careful and to use a gait belt. In an interview on 1/7/24 at 8:25 AM, Staff D, shower aide, reported it was standard for staff to use a gait belt whenever staff ambulated or transferred a resident unless it was listed on care plan otherwise. Staff D reported she heard Resident #1 had a fall. After the incident, staff were instructed to follow the resident's Care Plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 1/7/25 at 10:40 AM, the MDS Coordinator reported it depended on the level of assistance a resident needed and if a gait belt would be used. A few residents refused to use a gait belt, but the staff still offered and tried to educate the resident on why they needed to use a gait belt. Gait belt use would be listed on the resident's Care Plan. In an interview on 1/7/25 at 11:00 AM, the CNO reported she didn't think they had a Care Plan policy. An immediate (baseline) Care Plan is completed on admission, and the comprehensive Care Plan completed within 14 days. The CNO stated she talked with Staff A after Resident #1's fall. At the time, Staff A told her that Resident #1 was walking great so didn't use the gait belt. The CNO didn't think it registered with Staff A that a gait belt should be used. On 1/8/25 at 1:30 PM, the CNO confirmed no Care Plan policy found.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on record review, staff interviews, employee file review, and facility assessment, the facility failed to ensure nurse's aides possessed the competencies and skills necessary to safely transfer a resident as identified in the plan of care and resident assessment for 1 of 4 residents reviewed (Resident #1). The facility reported a census of 30 residents. Findings include: The Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 required partial to moderate assistance for transfers and ambulation. The Care Plan initiated on 6/11/24 revealed the resident required assistance with Activities of Daily Living (ADL's) and had a high risk of falls related to her age, limited mobility, and low back pain. The Care Plan directed staff to use a front wheeled walker, a gait belt and assistance of one for transfers and ambulation. An Incident Report dated 9/8/24 at 5:35 PM revealed Resident #1 sat on the floor on her buttocks with her back against the recliner and walker in front of the resident. Resident reported her knee gave out when she walked backwards to the chair. The resident reported pain in her left ankle. She had a history of weakness in her right knee and wore a knee brace. The resident tested positive for COVID-19. The incident report documented Staff A, Certified Nursing Assistant (CNA) statement about the incident: On 9/8/24, as me and the resident were walking to the recliner, the resident started turning to sit down. As she went to sit, her knee gave out and I guided her to the ground. The facility's investigation file included an incident summary (typed and written by the Chief Nursing Officer (CNO)). The incident summary revealed Resident #1 began showing signs and symptoms of COVID-19, and tested positive on 9/8/24 AM. On 9/8/24 at 5:35 PM, the CNA walked the resident from the bathroom back to the recliner chair. Per CNA statement, resident started to turn and her knee gave out as she began to sit. The CNA guided her to the floor. Resident complained of left ankle pain. The Physician's Assistant (PA) saw the resident on 9/9/24. X-ray results of left ankle indicated a fracture. Resident sent to the hospital for evaluation and treatment. The investigation of the incident revealed the following: After reviewing the CNA, Licensed Practical Nurse (LPN)), and resident statements, the type of injury, and resident's medical history, the CNO believed that the CNA ambulated the resident back to her recliner chair from the bathroom and the resident's right knee gave out. The resident wore a brace on her right knee and the brace was on when the occurrence happened. When the resident's right knee gave out, her weight shifted to her left leg. This happened as the resident was turning and it caused her left ankle to roll, which caused the fracture. The resident had to be lowered to the floor. A left ankle x-ray showed a fracture. The resident was sent to the hospital for evaluation and treatment. Review of Staff A's employee file on 1/6/25 at 3:00 PM revealed Staff A had a hire date of 5/30/24. The Direct Care Worker (DCW) registry document revealed Staff A's CNA certification date was 2/17/24. Staff A's employee file lacked an orientation checklist or any education completed. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Education Form dated 9/8/24 and signed by Staff A, Staff B (LPN), and the Assistant Director of Nursing (ADON) revealed the ADON provided written education to Staff A to use a gait belt. Resident #1 fell while she ambulated with staff and did not have a gaitbelt on. Staff lowered the resident to the floor. Staff A's response included I will from now on use a gait belt when transferring that resident. Review of education provided to the surveyor by the Chief Nursing Officer (CNO) on 1/7/25 at 11:40 AM, revealed Staff A attended a Safety Review/ Transfers Using Mechanical Lifts meeting on 8/1/24. Staff A also completed an EZ Way Smart Stand Competency Checklist dated 8/2/24, and an EZ Stand Competency Test dated 8/11/24. The education and competency checklist lacked information on gait belt use. In an interview on 1/6/25 at 2:45 PM, Staff B, LPN, reported the facility required a gait belt to be used unless the resident was independent or care planned otherwise. The CNO requested her to provide Staff A extra supervision and Staff A came to get her for transfers after Resident #1 had a fall. Staff B stated she also showed Staff A how to put on a gait belt. In an interview 1/6/25 at 3:45 PM, Staff A reported she had worked at the facility 5/2024 to 9/2024. She took a CNA course in high school in 3/2024. Her orientation at the facility entailed shadowing another CNA a total of four shifts. She only worked the weekend, and received her training on the weekend. She was unable to recall the CNA who trained her but she thought it was Staff E, CNA. She did not have anyone checking things off on an orientation checklist while in training that she recalled. She attended a few in-services when she was first hired. When she came to work, she got a copy of the resident list for her assigned area to reference if needed, and to know how a resident transferred and the cares or things a resident needed done. Staff A reported Resident #1 had a knee brace because her knee would be wonky and weak sometimes. She would ask Resident #1 if she was comfortable using the walker or if she wanted to use the wheelchair. The resident usually wanted to walk with her walker. Staff A reported she would follow behind Resident #1 with a wheelchair if the resident was weaker. Staff A acknowledged she worked on the day Resident #1 had a fall. The resident had COVID. The resident did ok with walking when she assisted the resident to the bathroom earlier that day. Later in the day, she helped the resident to the bathroom. Resident #1 did ok getting into the bathroom. Staff A reported she was holding the back of the resident's pants as the resident ambulated from the bathroom. As Resident #1 turned, her left knee gave out, and she stumbled up against the walker and the recliner. Staff A reported she lowered the resident to the ground. Staff A confirmed she did not have a gait belt on the resident. She only used a gait belt for those residents who really needed assistance. That was what she was told to do. She didn't use a gait belt much for Resident #1 because she didn't require as much assistance. The resident was groaning in pain. She pressed the emergency light and stayed with her until someone came in to help. Resident #1 didn't usually need much assistance. After the incident, a manager pulled her aside and had her sign a paper on what to do in the future. She was told she needed to use a gait belt when someone had COVID or was sicker. She had to sign a form that said she needed to be more careful and to use a gait belt. In an interview on 1/6/24 at 4:20 PM, the CNO, confirmed she was the one who wrote the incident summary and submitted it to Department of Inspections, Appeals, and Licensing (DIAL). The CNO reported she could not find an orientation checklist, competency checklist, or education in Staff A's file. The CNO reported she took the CNO position in 8/2024, and she was just learning her role when the incident happened with Resident #1. After the incident, there were a number of things they did, including staff education and getting gait belts for all of the staff. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/7/24 at 8:25 AM, Staff D, shower aide, reported she heard Resident #1 had a fall. After the incident, the facility went over transfers with the CNA's. They all got gait belts and were instructed to follow the resident's care plan. Staff D reported gait belt use as a standard for staff to use. A gait belt used anytime staff ambulated or transferred a resident unless it was listed on care plan otherwise. In an interview on 1/7/25 at 8:50 AM, the CNO provided the surveyor documents for education she found that was done on 8/1/24 with staff, as well as an EZ stand competency test completed on 8/11/24 and EZ Way Smart Stand competency checklist for Staff A completed on 8/2/24. The staff education entailed safety review/ transfers using mechanical lifts, utilizing two staff when operating any mechanical lifts for transfers including the EZ lift and Hoyer lift for maintaining the safety of both residents and staff. The education lacked information about gait belt use. In an interview on 1/7/25 at 11:00 AM, the CNO reported a CNA Orientation Checklist was developed after Resident #1's incident and an in-service was held with staff in 10/2024 (after Resident #1's incident). No CNA orientation checklist used prior to the incident that she could find, and the facility assessment contained information about staff education provided but she was unable to locate a policy for staff orientation. October 2024 was deemed fall prevention month. Staff had to watch a transfer with a gait belt and took a quiz. The CNO stated she talked with Staff A after Resident #1's fall. At the time, Staff A told her that Resident #1 was walking great so she didn't use the gait belt. The CNO didn't think it registered with Staff A that a gait belt should be used. In an interview on 1/7/25 at 1:25 PM, Staff E, CNA reported she trained new staff when they were hired but it had been a while ago. A new CNA typically got 3 days of orientation on the floor that she recalled but if a staff person didn't feel comfortable then they got more time in orientation. Staff E doesn't recall filling out an orientation checklist for new staff. In an interview on 1/7/25 at 2:45 PM, the CNO was asked how staff's competency and skill sets were evaluated upon their initial hire. The CNO reported she checked in with a new employee to see how they were doing with training/orientation after they were hired. It was more of a check-in with the staff member or the person doing the training, not something that she marked off in a competency. The new employee received on the job training, and their level of abilities were assessed at that time. In an interview on 1/8/25 at 1:15 PM, Staff F, RN, reported the QA Committee had a Performance Improvement Plan (PIP) on falls due to a number of residents had falls. The PIP focused on what staff should be doing to prevent falls. Staff F reported they would continue to provide staff education and reminders about using a gait belt as well as fall interventions. The Facility assessment dated [DATE] revealed staffing levels adjusted to meet the needs of residents, and the staff's strengths/weaknesses considered. Staff training included monthly computer-based in-services, a CNA mentor, and ongoing in-person educational events. A staff meeting dated 10/9/24 by the ADON revealed an agenda covering gait belt use. Staff A was not in attendance at the meeting.