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	05/06/2026

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** Based on observation, clinical record review, staff interview, and facility policy/procedure, the facility failed to ensure Resident #1 received a safe transfer to prevent a fall. The facility failed to follow safe mechanical lift techniques. This resulted in severe harm to a resident, who fell from a full-body mechanical lift and sustained life-threatening injuries including a subdermal hemorrhage (surface brain bleed), a subarachnoid hemorrhage (inner brain bleed), a type III dens fracture (broken neck bone), a right clavicle fracture (broken collarbone), and a left femur fracture (broken thigh bone) for 1 of 4 residents reviewed (Resident #1).The facility corrected the noncompliance prior to the beginning of the survey on 5/1/26 by doing the following:a.The facility-initiated education to staff on 4/30/26 by requiring staff to watch an in-service training video on the full-body mechanical lift's website and complete a quiz that correlates with the video prior to working their next shift.b.The facility initiated on 5/1/26 that staff had to complete hands-on education and demonstrate a safe transfer in compliance with the full-body mechanical lift operational manual with the facility's Quality Assurance Nurse.The facility reported a census of 29 residents.Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #1 depended on staff for bed mobility and transfers. The MDS included diagnoses of heart failure (weak heart), morbid obesity (severe overweight), and seizure disorder (convulsion condition).The Care Plan revised 9/16/24, revealed Resident #1 required help from 3 staff members with a full-body mechanical lift for transfers.The Nurse's Note dated 4/29/26 at 8:32 PM written by Staff A, Registered Nurse (RN), documented the Nursing Description as Staff A and Staff B, Licensed Practical Nurse (LPN), received a call to go to Resident #1's room immediately. Upon arriving, Staff A found Staff C, Certified Nursing Assistant (CNA), Staff D, CNA/Certified Medication Assistant (CMA), and Staff E, CNA/CMA, with Resident #1 on the floor with the full-body mechanical lift above her. Resident #1 had their left leg up on the couch with her head towards the bed. She had some blood on her left lateral shin with the bed covers open. Resident #1 used a loud voice to say help her as she wanted to get up. Resident #1 requested emergency medical services (EMS) to assist her getting up and the staff to call her Power of Attorney (POA), refusing the facility's staff assistance. The staff applied pressure by applying some gauze and wrapping the area to Resident #1's left shin to stop the bleeding until EMS arrived. Staff B attempted to assess Resident #1 and found she had a bump on the crown of her head. After EMS arrived, they assisted the facility staff in help Resident #1 into bed via the full-body mechanical lift. After Resident #1's POA persuaded Resident #1 to go to the hospital, she went via ambulance. She refused to allow the facility staff to perform any assessment. The note indicated Staff A initiated the hot charting (additional charting due to a change in resident's condition), the resident's 24-hour report, and the communication report. Staff A put an intervention in place for physical therapy (PT) and Occupational Therapy (OT) assist with providing reeducation on transfer where necessary to all staff.The Incident Report dated 4/29/26 at 8:32 PM written by Staff A documented the Nursing Description as Staff A and Staff B received a call to go to Resident #1's room immediately. Upon arriving, Staff A found Staff (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 0689 Level of Harm - Actual harm Residents Affected - Few	C, Staff D, and Staff E, with Resident #1 on the floor with the full-body mechanical lift above her. Resident #1 had their left leg up on the couch with her head towards the bed. She had some blood on her left lateral shin with the bed covers open. The Resident's Description indicated Resident #1 used a loud voice to say help her as she wanted to get up. Resident #1 requested EMS to assist her getting up and the staff to call her POA, refusing the facility's staff assistance. The staff applied pressure by applying some gauze and wrapping the area to Resident #1's left shin to stop the bleeding until EMS arrived. After Resident #1's POA persuaded Resident #1 to go to the hospital, she went via ambulance. She refused to allow the facility staff to perform any assessment. The Incident Report listed injuries to the top of Resident #1's scalp and left lower leg front.The Occurrence Witness Statement written by Staff C on 4/29/26, documented on 4/29/26 at 8:32 PM, 3 CNAs assisted Resident #1 in her room transfer, per her usual routine. Staff E operated the lift controls (driver), Staff D guided the legs, and Staff C pulled the wheelchair away once Resident #1 went up. Before lifting Resident #1, staff ensured everything remained in place. Staff C heard a snap and then observed Resident #1 on the floor, which prompted an immediate call to the nurse.The Occurrence Witness Statement written by Staff D on 4/29/26, indicated on 4/29/26 at 8:32 PM, as they assisted Resident #1 into bed using the full-body mechanical lift, Staff D heard a snap before watching Resident #1 fall to the floor on her right side. Staff E operated the lift, Staff D guided the feet, and Staff C moved the wheelchair. Staff C alerted Staff A and Staff B over the walkie-talkie.The Occurrence Witness Statement written by Staff E on 4/29/26, documented on 4/29/26 at 8:32 PM, they moved Resident #1 up in the full-body mechanical lift. Right before moving Resident #1 to the bed, Staff E observed Resident #1 fall from the lift and strike the floor headfirst. Staff E ran out to locate a nurse.The Trauma Consult/admission History and Physical dated 4/30/26 identified Resident #1 arrived to the emergency room (ER) following a fall from the full-body mechanical lift at her nursing home. The physical exam indicated Resident #1 had a c-collar (neck brace) in place with tenderness on palpation. The Computed Tomography (CT) scans (specialized imaging) and x-rays completed on 4/29/26, revealed a subdermal hemorrhage (SDH or a brain bleed), a subarachnoid hemorrhage (SAH or brain bleed), a type III dens fracture (broken neck), a right clavicle fracture (broken collarbone), and a left femur fracture (broken thighbone). She experienced pain in her right leg and neck. The plan directed to admit to the intensive care unit (ICU), consult neurosurgery (brain and spine surgeon), neck brace, and repeat CT imaging every 6 hours after initial head CT to evaluate the progression of her brain bleed.The ICU Trauma Progress Note dated 4/30/26 indicated they controlled Resident #1's pain with scheduled Tylenol, oxycodone (powerful opioid pain medication), and Dilaudid (powerful opioid pain medication) as needed (PRN). They held her blood thinners prophylactically (as a precaution) and she received a blood thickening medication when she arrived to the ER.On 5/4/26 at 2:00 PM Staff E stated she worked at the facility for 3 years. Staff E stated on 4/29/26 at approximately 8:30 PM, Staff C and Staff D prepared Resident #1 for bed. Staff E stated when she entered the room, Resident #1 sat in the wheelchair with the lift sling underneath her. Staff E stated she didn't attach any sling strap loops to the lift bar and she only operated the lift controls, while Staff C and Staff D attached the loops. Staff E stated she faced Resident #1 with the wheelchair positioned at an angle from the bed, and everything appeared normal. Staff E stated as she raised Resident #1 from the wheelchair using the hand control, Staff C removed the wheelchair. As she and Staff D attempted to turn Resident #1 toward the bed, Resident #1 fell to the floor. Staff E stated Resident #1 appeared level while raised in the air, but once Resident #1 landed on the floor, the right upper strap loop appeared unhooked. Staff E stated she didn't examine or check the lift straps or hoops to ensure secure attachment before or during the lift process. Staff E stated Resident #1 landed on her right side between the lift and the bed, and she observed Resident #1's face strike the floor. Staff E stated staff used the correct extra-large sling size, they always used. Staff E stated she didn't know what caused the loop to detach from the lift bar, and noted she received lift education from a vendor and a therapy staff member in the past.On 5/5/26 at 9:38 AM Staff A stated on 4/29/26 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	at approximately 8:30 PM, Staff C requested immediate assistance in Resident #1's room over the radio while Staff E went to find a nurse. Staff A stated he entered the room with Staff B directly behind him and found Resident #1 on the floor with her head toward the bed and her left leg on the couch. Staff A stated Resident #1's left shin bled, and Staff C applied tissue to the area. Staff A stated the full-body mechanical lift stood over Resident #1 with the left side sling loops attached, but the right-side loops appeared disconnected. Staff A stated Resident #1 panicked, demanded that staff lift her, then changed her mind, requesting EMS and someone to call her Representative. Staff A stated he called Resident #1's Representative with his phone and attempted to explain the need for an assessment, but Resident #1 refused to allow evaluations by him or Staff B. Staff A stated he left the room to contact emergency services and gather transfer paperwork. Staff A stated Staff C, Staff D, and Staff E reported Resident #1 was high in the air when they heard a snap and she fell. Staff A stated the CNAs reported using the same sling and lift to move Resident #1 from the floor to the bed with EMS assistance. Staff A stated Resident #1's care plan required 3 staff members and a full body lift for transfers, and he provided witness statement forms to the CNAs.On 5/5/26 at 10:10 AM Staff C stated she worked at the facility for two years. Staff C stated on 4/29/26 at approximately 8:30 PM, she, Staff E, and Staff D remained in Resident #1's room with Resident #1 in a wheelchair beside the bed. Staff C stated the full-body mechanical lift stood in front of Resident #1. Staff C stated Staff E operated the lift controls, Staff C stood behind the wheelchair, and Staff D stayed on the left side. Staff C stated she didn't remember who attached the straps, but staff always secured the top straps to the black loop and the bottom straps to the loosest green loop. Staff C stated the wheelchair remained locked until Resident #1 went into the air, and then Staff C moved the wheelchair away. Staff C stated she heard a snap, turned around, and observed Resident #1 on the floor. Staff C stated one sling loop appeared unhooked from the lift bar. Staff C stated staff used the same sling and lift to transfer Resident #1 to the bed and gurney. Staff C stated Resident #1 normally leaned to the right in the wheelchair and shifted slightly right when suspended in the sling. Staff C stated all transfers utilized the full-body mechanical lift, three staff, and an extra-large sling. Staff C stated she completed two prior lift transfers with Resident #1 that day. Staff C stated she did not feel certain who hooked up the sling strap loops when the fall occurred. Staff C stated protocol required one staff member to check all loops to ensure secure attachment before lifting a resident, but she didn't recall specifically if anyone performed the check before lifting Resident #1.On 5/6/26 at 1:47 PM Staff D stated on 4/29/26 at approximately 8:30 PM, she and Staff C entered Resident #1's room to assist with bed preparation, and Staff E arrived to help with the transfer. Staff D stated Resident #1 sat in the wheelchair with Staff C on the right side and Staff D on the left side. Staff D stated Staff E entered the room while staff hooked the lift sling strap loops onto the lift. Staff D stated she attached the loops on the left side, and Staff C attached the loops on the right side. Staff D stated protocol didn't require a double check because the loops simply hook in, with the black loop on top and the loosest loop on the bottom. Staff D stated Staff E raised Resident #1 completely up, Staff C moved the wheelchair, Staff E turned the lift, and Resident #1 fell directly to the floor. Staff D stated Resident #1 landed on her right side with a loud thunk. Staff D stated the straps didn't break because staff reused the sling afterward. Staff D stated she didn't know if any loops disconnected during the fall. Staff D stated she watched Resident #1's feet instead of the hooks, and noted Resident #1 appeared slightly crooked in the air. Staff D stated a safe transfer required one staff to guide the feet, one to manage the wheelchair, and one to operate the controls and monitor the straps because that person possessed the best view.On 5/6/26 at 4:00 PM Staff B stated on 4/29/26 at approximately 8:30 PM, a call summoned her to Resident #1's room. Staff B stated she found Staff A, Staff C, Staff D, and Staff E in the room with Resident #1 on the floor alternating between shouting for help and telling staff not to touch her. Staff B stated Resident #1 panicked, so she attempted to calm her while Staff A contacted EMS. Staff B stated the lift stood near the door and the sling did not remain underneath Resident #1 when she arrived. Staff B stated she remained with Resident #1 until EMS (continued on next page)

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