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	07/18/2024

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 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. 34817 Based on record review, staff interview, and the RAI (resident assessment instrument) manual review, the facility failed to complete and transmit the resident's minimum data set assessment within the required timeframe for 4 of 12 residents sampled (Resident #2, #7, #9, and #16). The facility reported a census of 32 residents. Findings include: Review of Resident #2's Quarterly Minimum Data Set (MDS) assessment tool dated 4/26/24 revealed the quarterly MDS assessment status as in progress. The MDS summary revealed the MDS assessment needed completed by 5/10/24. The MDS summary revealed the assessment had 13 errors under the validation icon. The MDS revealed sections A, GG, H, I, J, L, M, N, O, and P in progress. Review of Resident #7's Quarterly MDS assessment tool dated 4/19/24 revealed the quarterly MDS assessment status as in progress. The MDS summary revealed the assessment needed completed by 5/3/24. The summary also indicated the MDS assessment had 25 errors and 1 warning. The MDS revealed sections A, B, GG, H, I, J, K, L, M, N, O, P, and Q in progress. Review of Resident #9's Quarterly MDS assessment tool dated 4/19/24 revealed the quarterly MDS assessment as in progress. The MDS assessment needed completed by 5/3/24. The summary also indicated the MDS assessment had 23 errors and 2 warnings. The MDS revealed sections A, B, GG, H, I, J, L, M, N, O, and P in progress. Review of Resident #16's Quarterly MDS assessment tool dated 4/26/24 revealed the quarterly MDS assessment status as in progress. The MDS summary revealed the assessment needed completed by 5/10/24. The summary also indicated the MDS assessment had 13 errors. The MDS revealed sections A, GG, H, I, J, L, M, N, O, and P in progress. (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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/17/24 at 2:46 PM, Staff A, MDS Coordinator, reported she had worked at the facility since 5/8/24. Prior to this, the Director of Nursing (DON) worked on the MDS assessments. The social worker, dietary manager, and the activities director also completed certain sections on the MDS assessment. Staff A reported she reviewed all MDS sections to ensure all of the assessment areas completed and the information correct before the MDS exported and submitted to CMS (Center for Medicare Services). Staff A stated the residents' MDS assessments completed whenever a resident admitted to the facility, quarterly, and anytime the resident had a significant change in status. Staff A acknowledged a number of MDS assessments incomplete but the MDS Assessment Review Date (ARD) were prior to the date she started to work. She was told to complete the MDS assessments from the ARD of 5/8/24 and going forward. She couldn't complete the MDS assessments prior to 5/8/24 because she wasn't working at the facility during that time and had not interviewed the residents or staff or completed the record reviews at that time. In an interview 7/17/24 at 3:00 PM, the DON reported she and the Assistant Director of Nursing (ADON) worked on the resident MDS assessments prior to Staff A. The DON reported another staff member worked on MDS assessments but left the facility without notice in 12/2023 after she spoke to the staff member about timeliness of MDS completions. The facility tried to recruit another MDS coordinator but in the meantime the ADON and DON worked on the MDS assessments. The DON confirmed Staff A started as the MDS Coordinator in 5/2024. The DON reported she had self-identified a concern about MDS completions and submissions not done in a timely manner in 12/2023 when the MDS Coordinator resigned without notice. She put together an action plan to address the concern. In an email dated 7/18/24 at 10:05 AM, the DON wrote no written policy on MDS Assessments. It is expected staff followed the CMS guidelines as noted in the RAI Manual. The MDS 3.0 RAI Manual dated 10/2019 revealed Timeliness criteria under section 5.2. In accordance with the requirements at 42 CFR S483.20(f)(1), (f)(2), and (f)(3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions: For all non-Admission OBRA and PPS assessments, the MDS completion date must be no later than 14 days after the ARD.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observations, and staff interview, the facility failed to develop and implement a comprehensive person centered care plan for 1 of 12 residents reviewed (Residents #7). The facility reported a census of 32 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had diagnoses of COVID-19, heart failure, and end-stage renal (kidney) disease. The MDS indicated the resident used oxygen (O2). The Care Plan revised on 6/28/24 revealed the resident had congestive heart failure and COVID-19. The Care Plan lacked information about the resident's O2 use, and the interventions related to the management, use, and care of the O2. The Physician's Order Summary revealed an order started on 3/28/24 for O2 at 1-5 liters (L) per nasal cannula (NC) titrated to keep the resident's oxygen saturation above 90% for perfusion, and to change the O2 tubing every Sunday on the evening shift for infection control. Observations revealed the following: a. On 7/15/24 at 11:12 AM, Resident #7 had O2 on at 3 1/2 L via NC. b. On 7/17/24 at 10:30 AM, Resident #7 had O2 on 3L via NC. c. On 7/18/24 at 11:40 AM, Resident #7 had O2 on at 3L/NC. In an interview 7/17/24 at 2:46 PM, Staff A, MDS Coordinator reported she had worked at the facility since 5/8/24. She developed and revised the residents' care plans as needed. She obtained information from chart reviews and staff interviews to complete and update the care plans. Staff A confirmed O2 should be listed on the care plan if a resident had or used O2. In an email dated 7/18/24 at 10:05 AM, the Director of Nursing (DON) wrote they did not have a policy on care plans. In an interview 7/18/24 at 12:48 PM, the DON reported she expected O2 listed on the care plan If a resident had O2.

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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	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 clinical record review, observations, resident and staff interviews, and manufacturer manual instructions, the facility failed to appropriately use an EZ stand mechanical lift and transfer a resident safely for 1 of 3 residents reviewed for transfers (Resident #2). The facility reported a census of 32 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident#2 had diagnoses of cerebrovascular accident (CVA) (stroke), right shoulder pain, and a seizure disorder. The MDS documented the resident required substantial to maximum assistance for bed mobility and transfers. The MDS also revealed the resident had one fall without injury. A Significant Change MDS assessment dated [DATE] revealed Resident #2 had diagnoses of osteoporosis, right shoulder pain, a fracture, and CVA. The MDS documented the resident had a brief interview for mental status (BIMS) score of 15, which indicated cognition intact. The MDS documented the resident dependent for transfers. The MDS revealed the resident had a fall with a major injury. The Care Plan revised 10/30/23 revealed Resident#2 had decreased mobility and functional ability, chronic shoulder pain, and had a high risk for falls due to chronic weakness on the left side of her body due to a history of stroke, and a history of a fall with a fracture. The care plan directed staff to use an EZ stand and two staff for transfers was initiated on 5/16/22. In an interview 7/15/24 at 11:08 AM, Resident#2 reported she had a fall and fractured her shoulder in 2/2024. The resident stated the strap broke loose while she stood on the EZ stand. She went to the hospital and then saw an Orthopedic physician. She also had another incident a couple of months ago while staff were in the process of doing a treatment on her bottom. She stood on the EZ stand during the treatment but she couldn't stand up any longer, and staff lowered her to the floor. The Nursing: Fall Risk Form revealed the following fall risk status: a. On 7/5/2023, the resident had a low risk for falls. The fall risk interventions included to use an EZ stand as needed b. On 1/15/2024, the resident had a moderate risk for falls. The fall risk intervention included to use the Hoyer mechanical lift until Physical Therapy (PT) and Occupational Therapy (OT) evaluated the resident for transfers. c. On 5/22/2024, the resident had a high risk for falls. The fall risk intervention included to consult PT and OT for re-evaluation on transfers. The Nursing Admission assessment dated [DATE] revealed the resident had a high risk for falls. The Progress Notes documented the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a. On 7/5/23 at 8:55 AM, Certified Nursing Assistant (CNA) lowered resident to the floor in the shower. The CNA stated they tried to move the resident from the wheelchair to the shower chair, the resident sat on the edge of the shower chair, but they couldn't get her buttocks all the way into the shower chair. The resident could no longer stand so staff lowered her to the floor. No injuries noted. An intervention implemented included to use an EZ Stand as needed. b. On 1/15/24 at 3:43 PM, Staff B, Registered Nurse (RN), told Staff J, RN, Resident #2 lying on the floor. The resident found lying on her back with pillows under her head and sides upon Staff J's entry to the room. Staff had already removed the EZ stand pad from behind her. The resident stated The strap just snapped off the right side of the EZ stand and I let go. Something snapped in my right shoulder and it hurts really bad. I fell to the floor after that happened. The resident complained of pain in her right shoulder. A Nurse Practitioner (NP) already at the facility came and assessed the resident's shoulder and ordered an x-ray. Floor nursing staff notified to give Tylenol for discomfort. The resident denied hitting her head. Immediate intervention included to utilize a Hoyer lift for transfers and a PT/OT evaluation for transfer and strengthening. Director of Nursing (DON) notified of the incident. At 4:30 PM, an order received to send the resident to the Emergency Department (ED) for evaluation and treatment related to the fall and the resident had right shoulder pain. On 1/16/24 at 1:44 AM, resident returned from the ED visit around 1:00 AM. The resident suffered a displaced impacted and comminuted fracture of the humeral neck (right shoulder). The resident had a sling on her right arm. She received Fentanyl (a narcotic) injection and Norco (oral pain medication) while in the ED. c. On 5/22/24 at 5:16 PM, Staff F, CNA, and Staff C, CNA, stood the resident in the EZ stand while Staff J, RN, stood behind the resident and performed a treatment. When the resident said she could not hold on, Staff J attempted to place the dressing quickly and get the wheelchair under the resident. The resident stated she was losing her grip on the EZ stand and her right arm let go. Once the resident's right hand let go of the stand, she slid down in the sling. The resident's bottom already fell below the level of the seat on the wheelchair. Staff C tried to slide her knee underneath the resident to hold her up but was unable so Staff J held her from behind while Staff F and Staff C placed an arm around her and their other arm under one of the resident's legs and then lowered the resident to the floor. The resident was then detached from the EZ stand fully. Staff then used a Hoyer lift and transferred the resident into her wheelchair. The resident complained of arm pain rated at 4 out of 10 at the time of the incident. She denied the need for pain medication. The resident had a history of stroke affecting her left side and a history of humeral fracture of the right upper arm. Her level of weakness is variable throughout the day. Resident lost her grip on the EZ stand while in the standing position. DON notified immediately after the incident. Incident Reports revealed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a. On 1/15/24 at 3:43 PM, Staff B, RN, told Staff J, RN, Resident #2 lying on the floor. Resident #2 found lying on the floor on her back with pillows under her head and sides when Staff J walked into the resident's room. Staff had already removed the EZ stand pad from behind her. The resident stated The strap just snapped off the right side of the EZ stand and I let go. Something snapped in my right shoulder and it hurts really bad. I fell to the floor after that happened. The resident complained of pain in her right shoulder. A NP already in the facility assessed the resident's shoulder and ordered an x-ray. Resident rolled side to side and a lift sling placed under her, then staff transferred her via a Hoyer lift from the floor to her bed. The resident rated her pain at 8 on a 1-10 pain scale. APAP (Tylenol) administered for discomfort. Immediate intervention included to request staff utilize the Hoyer lift for transfers in the future and a PT/OT evaluation for transfers and strength. Resident representative and the on-call manager (DON) notified of the incident. The predisposing situational factors listed on the incident report included: An EZ stand used for transferring the resident. She lost her grip on the machine causing the EZ stand to unbalance. The incident report revealed a follow-up note added on 1/28/24 about the fall occurrence with injury on 1/15/24. An EZ stand used to transfer the resident from the the commode to the recliner. The resident had pain in her arm that caused her to let go of the machine and it unbalanced. The resident was lowered to the floor. Only one staff member in the room at the time of the incident. Staff education provided about the need to have a second person whenever staff moved the machine with a resident in it. The resident complained of right shoulder pain. The NP assessed the resident and then sent her to the ED for x-rays. No other injuries noted at the time. Immediate intervention included to use a Hoyer lift for transfers until PT/OT assessed the resident. b. On 5/22/24 at 4:26 PM, Staff J, RN, Staff F, CNA, and Staff C, CNA were in the resident's room to stand her in the EZ stand in order for the nurse to perform a treatment. The resident stood in the EZ stand as the nurse stood behind her. The resident said she could not hold on. Staff J documented she attempted to place the dressing quickly and position the wheelchair under the resident. The resident's bottom was already below the level of the seat on the chair. The resident stated that she was losing her grip on the EZ stand and her right hand let go of the lift bar, then she started to slide down in the sling. Staff C tried to slide her knee underneath the resident to hold her up but was unable. Staff J then held the resident from behind and both CNA's lowered the resident to the floor. She was then detached from the EZ stand. Staff then placed a Hoyer sling underneath her and transferred her into a wheelchair. The resident reported pain in her arm rated at 4 out of 10 at the time of the incident. She denied the need for pain medication after staff placed her in the chair and made her comfortable. No injuries observed. Resident oriented to person ,place, time, and situation. Predisposing situational factors included: Resident had a history of stroke affecting her left side and a history of humeral fracture of the right upper arm. Her level of weakness was variable throughout the day. Resident lost her grip on the EZ stand while in the standing position. The report revealed follow-up notes added on the following: 5/28/24 - resident had a fall and lowered to the floor. The resident let go of the EZ stand during a transfer and slid downward. Three staff lowered her to the floor. PT/OT consulted regarding transfers. 6/28/24 at 2:00 PM, the occurrence was unlocked per resident / representative request to add additional documentation and include the resident's voiced concerns. Discussed with the Assistant Director of Nursing (ADON). The resident's request and additional detail will be added. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	6/29/24 at 9:36 AM, additional information added to the occurrence report per the resident and representative's request. Resident was asked prior to standing in the EZ stand if she felt she had the strength to do so at the time. Resident stated she thought so. Once the resident stood up in the EZ stand and dressing removed from her bottom, she stated It hurt and requested to be put down now. Staff J asked for a few more moments to put the new dressing on. The resident then started to repeat several times back to back the same thing while RN put the new dressing on and pulled her skirt back down. As the nurse pulled the resident's skirt down, the resident let go of the EZ stand (and the rest of what happened in the original note occurred. The whole incident from when she originally stated she would like to be put back down to her being lowered to the floor took approximately a minute and a half. The Emergency Department provider note dated 1/15/24 at 5:31 PM revealed the resident presented to the ED complaining of shoulder pain. The resident reported that around 2:00 PM, a strap broke while she used an EZ stand lift at the care facility, and she fell . The resident landed on her bottom but her right arm swung down and she immediately had pain. The resident had prior history of a Stroke (CVA), which caused chronic weakness on her left side. A shoulder x-ray revealed the resident sustained a displaced fracture of the right humerus. A CT scan of the right shoulder also revealed the resident had severe osteoarthritis. Treatment included a sling placed on the right arm and pain medication provided. An Occurrence Witness Statement signed by Staff G, CNA, revealed: on 1/15/24 and 3:00 PM, Resident#2 transferred from the commode to a recliner in an EZ stand. The resident's arm started to slip and staff lowered her to the floor. An Occurrence Witness Statement written by Staff F on 5/22/24, revealed on 5/22/24 at 4:00 PM, Resident #2 unable to hold on while she stood in the EZ stand. Staff lowered her down. An Occurrence Witness Statement written by Staff C on 5/22/24 revealed on 5/22/24 at 4:30 PM, the resident stood in an EZ stand for a treatment on her bottom. While staff in the process of finishing up a treatment to an open area, the resident stated she needed to sit. She lost her grip, and Staff C and Staff J lowered her to the floor. A Major Injury Determination form signed by the physician on 1/17/24 at 11:00 AM revealed Resident #2 reported she felt a pop and unable to hold onto the EZ stand, and she fell to the ground. The resident had a right humerus fracture. The physician marked the injury sustained not a major injury pursuant to the Iowa Administrative Code 50.7(1)(a)(3). During observations on 7/17/24 at 10:39 AM, Staff C, Certified Nursing Assistant (CNA), and Staff D, CNA, placed a wheelchair near the resident's bed and locked brakes. Staff placed a Hoyer sling in the seat of the wheelchair. Staff C and Staff D sat the resident on the edge of the bed. Staff C adjusted the foot platform on the EZ stand, and placed the resident's feet onto the EZ stand platform. Staff placed a strap around the resident's legs, placed a sling behind the resident's back, and attached the sling straps to the EZ stand. The resident placed her hands on the EZ stand bars. Staff stood the resident up with EZ stand and transferred her to a bariatric wheelchair. The EZ stand legs were opened outward during the transfer, but staff had to close the EZ stand legs to get the EZ stand to fit and move around the bariatric-sized wheelchair wheels. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview 7/16/24 at 12:55 PM, the Director of Nursing (DON) reported when a resident had a fall, staff filled out an incident/fall report, completed a fall risk assessment, and put an intervention in place. In an interview 7/17/24 at 10:53 AM, Staff C, CNA, reported she had worked at the facility for 4 months. Resident #2 used an EZ stand for transfers. The resident had one fall that she knew of since she started working at the facility. The resident's arm gave out while she held onto the EZ stand, and she lowered her to the floor. Staff C reported therapy had worked with the resident to help strengthen her arm and shoulder. In an interview 7/17/24 at 2:39 PM Staff E, Registered Nurse (RN), reported a Hoyer used when Resident#2 transferred but then changed to using an EZ stand lift for transfers after therapy worked with her. The resident had strength and pain issues, and would refuse to use the EZ stand a lot. Staff E reported she wasn't working when the resident had falls from the EZ stand lift. In an interview 7/17/24 at 3:00 PM, the DON reported Resident #2 had had a couple of falls while staff used an EZ stand lift. The DON stated a major injury determination form was filled out when the resident fractured her shoulder and the injury was determined not to be a major injury. The DON acknowledged she did not report to the State Department of Inspections, Appeals, and Licensing (DIAL) when the resident had a fall with fracture and transferred to the Emergency Department (ED) because the incident was not a reportable incident, and her injury wasn't classified as a major injury. The DON reported she recently reopened the fall incident from the EZ stand that happened the second time. A nurse came to the DON and said the resident's family asked for documentation and wondered if they were allowed to give the documentation to them. The resident had a fall from the EZ stand, the nurse was in the process of doing a treatment while the resident stood on the EZ stand. The resident said she couldn't stand any longer. The nurse asked her to hold on as she placed the dressing on her bottom. Staff placed a chair under her but she missed the chair, and staff lowered her to the ground. There were 3 staff in the room at that time. At the end of 6/2024, the family requested a meeting. She was in the process of re-reviewing the incident. Resident#2 had concerns the nurse didn't listen to her. The nurse explained what happened and got witness statements. The first fall from the EZ stand incident occurred (1.2024), the resident told her she was in the EZ stand and she felt a pop. The resident said it hurts, she let go of the bar, and she fell down. During an interview 7/18/24 at 9:20 AM, Staff B, RN, stated he wasn't in the room when Resident #2 had a fall from the EZ stand lift. He assumed the resident couldn't hang on while in the EZ stand. The resident normally used an EZ stand for transfers. She is a large lady, and it's a lot of weight to support for her and the machine when she held onto the EZ stand. Staff need to put the footstand up to the middle when they used the EZ stand on Resident #2, due to her legs aren't long enough to touch the platform at the regular height. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview 7/18/24 at 9:55 AM, Staff F, Certified Medication Aide (CMA) reported she worked the 2-10 PM shift. Two staff needed to transfer a resident whenever an EZ stand lift is used, and needed to make sure the resident could hold onto the EZ stand and use their arms to hold the bars. Staff F explained the process of use and transfer of resident with an EZ stand. A strap placed around the resident's legs and feet positioned on the platform. A vest sling placed and the belt buckled around the waist. Straps hooked onto the EZ stand lift. Staff F reported a sizing chart was kept in the pocket of the lift stand, but she looked at the sling and size of the resident to determine if it was the correct size sling for the resident. Staff F reported Resident#2 used a Hoyer for transfers, but sometimes used the EZ stand during the day. She normally used the Hoyer in the evening. Staff F reported a couple months ago, she walked in while the resident stood in the EZ stand, and her arm gave away. The nurse was doing a treatment or looking at her bottom. They tried to get her into the chair but she couldn't stand back up or hold herself up any longer. She had slid down and they couldn't get her back into her chair, so they slowly moved her to the floor. She didn't have any injuries. She was a little scared. This was the only time the resident had a fall or EZ stand lift incident that she knew of. During an interview 7/18/24 at 9:44 AM, Staff G, CNA, reported two staff at all times whenever an EZ stand lift used. Use the EZ stand lift lever to open the legs all of the way when going to the recliner or the wheelchair in order to get the EZ stand lift legs in position by the wheelchair or wherever needed. She closed the EZ stand lift lever after the resident was in position and unhooked, then pulled the machine back and closed the legs. Staff G stated Resident #2 used the EZ stand lift if she had a good day. The resident got nervous when they planned to use the EZ stand. Staff G reported the resident's arm doesn't go all the way up, and it was hard for her to hold herself up when they lifted her up with the lift. Staff G reported the resident had a fall. On the day she worked, she moved the resident from the commode to the recliner. The resident couldn't hold onto the EZ stand bar any longer, she let go, and then fell . She thought maybe she sprained or broke her shoulder. She got a pillow and placed the pillow by the resident and the other CNA went to get the nurse. Prior to the transfer, she asked her how she she felt and if she could use the EZ stand. They also put a Hoyer sling in her wheelchair in preparation for later in the day in case she didn't feel strong enough to use the EZ stand. (continued on next page)

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	165593	A. Building B. Wing	07/18/2024

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.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview 7/18/24 at 10:00 AM, Staff J, RN, reported Resident#2 required the assistance of 1-2 staff for cares, and used an EZ stand for transfers. Use of the EZ stand worked well on some days for Resident#2, but not so well on other days. She had increased weakness since 1/2024 when she broke her arm. Her care plan included to use a Hoyer in the evening instead of an EZ stand lift. The resident had a wound to her sacral/coccyx area that included a treatment with collagen and an optifoam dressing. Staff J reported on the day of incident, she performed wound care to the resident's bottom while the resident stood in an EZ stand. Prior to this, the resident sat in the recliner chair. She didn't want to go to bed. Staff J asked if she could stand in the EZ stand. Staff stood her up in the EZ stand and then Staff J proceeded to do the wound treatment. While Staff J performed the treatment, the resident told her it hurts, it hurts and let go of the EZ stand. Staff J reported she tried to put the chair under the resident but her bottom was already lower than the chair. She couldn't get the wheelchair because she stood behind the resident. She had no place to go. The recliner was behind her, the EZ stand and resident were in front of her, and the staff CNA's stood by the resident. Staff C couldn't get the wheelchair from where she stood. They lowered the resident to the floor. The resident used the Hoyer lift and only used the EZ stand for transfers now, and she no longer performed the treatment while the resident stood in the EZ stand. At the time, Staff J checked the resident's care plan in the electronic health record and confirmed the intervention to only use the EZ stand for transfers from/to the bed, chair, wheelchair not listed on the care plan. Staff J reported the resident also had a fall in 1/2024 when the CNA moved the resident from the commode to the recliner. Staff J stated she was not in the room when the incident happened. Staff came and told her the resident had fallen and asked her to go see the resident. She asked the Physician's Assistant (PA) to see the resident. The resident got sent to the ED. Staff J reported more than one CNA in the room when she got to the room and saw the resident but she didn't know how many staff were in the room during the transfer or at the time of the fall. Staff J reported the steps for EZ stand lift use: move the resident to the edge of the bed, a sling placed around the resident, the strap around the chest tightened, and the leg strap buckled. Ensure the resident held onto the bar on the outside of the bar. One staff lifted the resident up while another staff person held onto the handle attached to the back of the sling. Wheel the resident in the EZ stand to the chair, toilet, or wheelchair, then unhook the sling after the resident placed in the chair. Staff J reported the leg bar on the EZ stand lift together (closed) while or whenever moved the resident. The EZ stand legs moved outward (apart) when the resident placed into the chair or wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In a follow up interview 7/18/24 at 11:15 AM, Resident#2 reported she had incurred two falls from the EZ stand. The first one occurred when a CNA transferred her from the commode to the recliner. There was only one CNA in the room at that time. The resident stated she held onto the EZ stand but had pain in her right shoulder and couldn't hold onto to the bar, and she fell . She fractured her upper right arm in two places. The second incident occurred in May 2024, when a nurse was doing a treatment on her bottom. She told the nurse she couldn't stand any longer but the nurse told her she was almost done. Staff lowered her to the floor because she could not hold onto the bar any longer. The resident stated she was afraid to use the EZ stand because she feared she was going to fall. She let staff know if she thought her arm felt too weak that day. The resident stated she wanted to be able to use the EZ stand but on some days she didn't feel strong enough to use the EZ stand. On those days, staff have accommodated her request to use the Hoyer lift instead. The resident stated when she had a fall and fractured her shoulder/arm, she thought something was wrong, She had so much pain. She asked staff to call the ambulance but they didn't call the ambulance or 911 right away. Staff placed her in the Hoyer, moved her into bed, and then had the doctor see her. Later, staff called an ambulance. Staff moved her from the bed to the ambulance cot, then she had to be moved from the cot onto a cart in the ED. She was in pain and she had to be moved several times. She felt being moved several times was unnecessary and thought staff should have called the ambulance when she requested. In an email sent 7/18/24 at 11:20 AM, the DON wrote they don't have a specific policy regarding use of the EZ-Stand. The facility staff followed the manufacture's recommendations and/or therapy recommendations. During an interview 7/18/24 at 12:05 PM, Staff K, Physical Therapist, reported therapy made recommendations whenever a resident completed therapy services. Resident #2 had worked with PT. She had pain in her shoulder and therapy said it would be ok for her to use the Hoyer for transfers. She talked to staff about putting the Hoyer sling in the wheelchair or recliner to have option to use Hoyer if the resident didn't feel like she could stand and use the EZ stand at that time. During her therapy sessions, the resident had the tolerance to stand for only up to a minute, then she requested to sit down because she had pain. Staff K reported the EZ stand operated as follows: spread the leg bar out to start. If had to go through a doorway, pull on the lever and close the legs spreader bar. The spreader bar should be kept open while transferred the resident for balance so the EZ stand and/or resident don't tip. The EZ stand lifts had weight limitations. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview 7/18/24 at 12:48 PM, the DON reported no competency checklist or policy for EZ stand transfers. An EZ Way stand manual kept at the nurse's station. She didn't think staff knew the location of the manual. A CNA reference book also kept at the nurse's station for staff to review information inside but the EZ Way stand manual information not kept in the CNA reference book. Resident #2 required assistance of one staff and used a four wheeled walker (since 10/29/2023) and until she had her first fall from the EZ stand. Her transfer status changed to a Hoyer lift after she returned from the ED and had a fractured arm. At the time, the surveyor reviewed the resident's Care Plan and confirmed with the DON when the resident's transfer statuses changed. The surveyor questioned if the resident required assistance of one staff and front wheeled walker, why an EZ stand used. The DON explained the resident had just had the flu and the resident used the EZ stand at that time due to weakness. The DON confirmed she wasn't in the room when the resident had the fall. Staff called her to let her know about the fall. The next day she noted staff had documented the sling broke. She went and talked to the resident the day after her fall. The CNA used an EZ stand to transfer the resident when she felt a pop and fell down. The resident complained her arm hurt. Staff then placed her in bed. The NP was at the facility and saw the resident. Staff called to get an x-ray but x-ray didn't come right away, staff ended up sending her to the hospital before they got an x-ray. After she spoke with the resident she went and found all of the slings and none were in disrepair and she didn't find any frayed slings. The DON explained a second fall incident occurred while the resident used an EZ stand lift. During that time, Staff J performed a treatment while the resident stood in the EZ stand. Staff J had asked the resident if she felt ok to stand for the treatment. Resident #2 told staff she wanted to sit back down. Staff J said she needed to put the dressing on. Staff J put the dressing on, pulled the resident's skirt down, then tried to put the chair under her, but the resident's bottom was lower then the wheelchair and she missed the seat of the wheelchair, so they lowered her to the floor. The DON stated she did not talk to the resident after this occurrence because the appropriate staff were in the room, staff followed the resident's care plan, and the resident did not ask to speak with her. A family member requested to speak to the DON last month because the resident didn't think staff documented the incident accurately and the documentation didn't reflect what happened. The family member didn't think the resident's voice was reflected in the documentation. She didn't think the incident had been followed up appropriately. The DON told her she would have the nurse edit the documentation. The family wanted the notes to reflect what the resident said. The DON stated the incident report had additional information on it. She said she would have Staff J add the information to the incident report and progress notes. The DON acknowledged she didn't report Resident #2's fall with fracture incident to the State (DIAL). The DON reported Resident #2 preferred to use the EZ stand but she basically told the staff which mechanical lift to use when they transferred her. The resident is fearful of using the EZ stand and Hoyer. It's her preference on which one staff used, and it depended upon how she felt and if she felt strong enough at that time. During an interview 7/18/24 at 10:52 AM, Staff H, CMA, explained how she used an EZ stand lift whenever she transferred a resident. First, the EZ stand lift placed in line with the resident on the bed or wherever the resident sat. Place the resident's feet on the pedal (platform). Attach the straps to the machine. Assess straps and the resident's comfort level and adjust the straps accordingly. Lift the resident up in the EZ stand lift. The EZ stand's leg bar opened (extended out) for stability whenever the resident transported. It's a fall risk to close them. The leg bar only closed when the EZ stand placed under the wheelchair, bed, or chair and sat or lying the resident down. Staff H stated a resident immediately placed back into the wheelchair, chair, or bed if the resident unable to stand or had pain. Another way found to complete cares after the resident is safe and comfortable. Slings are based on how much a resident weighs and also had some height restrictions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview 7/18/24 at 10:50 AM, Staff I, CNA, reported they needed two staff whenever an EZ stand mechanical lift used to transfer a resident. She made sure the resident's feet positioned onto the easy stand platform and leg strap on. A different sized slings used based on the resident's weight and height. The EZ stand leg bar is supposed to be in the open position to ensure proper balance of the machine and resident, and then the machine leg bar closed after the resident placed into the chair or wheelchair. Staff I stated a resident should be placed into the chair or bed and sat down if a resident said they couldn't stand anymore. A Mechanical Lift protocol dated 2/1/24, provided by the facility on 7/18/24 revealed it is the facility's intent to ensure a resident's safety in the event that a resident requested or required use of a mechanical lift for transfers and/or mobility. Nursing will follow manufacturer's recommendations whenever a mechanical lift used. A mechanical lift skills checklist revealed the following steps: 1.Secure the assistance needed (at a minimum, dependent on the lift). 2. Position a chair next to bed; if using a wheelchair, ensure that brakes are locked. 3. Slide the sling under the resident 4. Be sure all locks and straps are fastened securely and correctly and the base of the lift is positioned correctly. 5. Slowly raise the resident 6. Have an assistant guide the resident's legs and lower the resident carefully into position. 7. Remove equipment Review of the facility provided EZ Way Stand Operator's Instructions Manual revised 9/29/23, revealed the following: The EZ Way stand used to transfer weight bearing patients to and from a chair, wheelchair, toilet, or bed. Patients should be able to bear some weight, have upper body strength, and be able to follow simple commands. If a patient does not meet each of these three criteria, an EZ Way total body lift must be used. The procedural steps for operation of the EZ Way Stand and transferring a patient included: a. Attach the harness to the hooks at the end of the stand arm. Make sure to [TRUNCATED]